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EDITED BY
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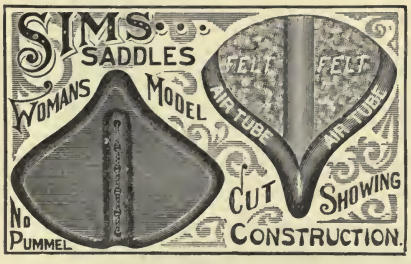

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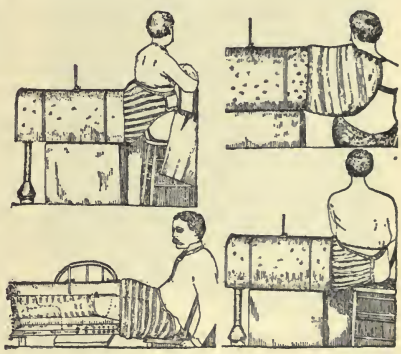

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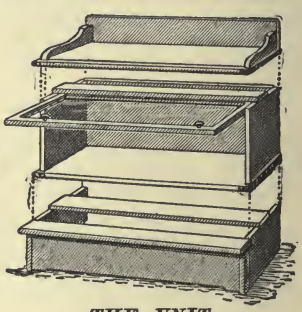

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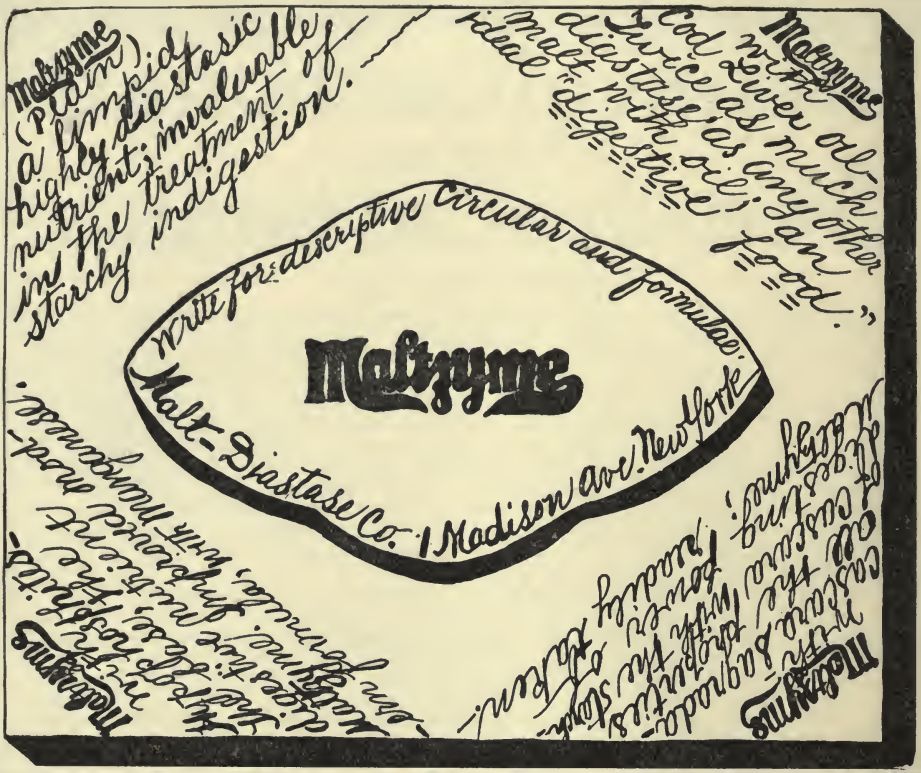

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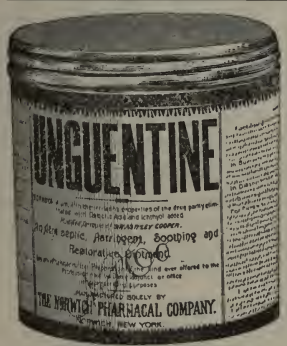

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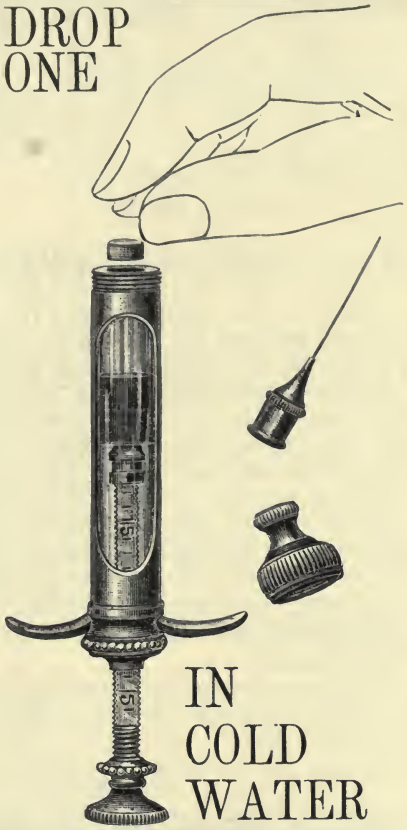

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Cyclopædia of the Year's Literature.

CHOREA.

Symptoms.—Monroe[1] finds that involuntary movement, muscular weakness, and muscular rigidity are three symptoms belonging to the group that depends on impaired functional integrity of the upper segment of the motor path. They are found in two diseases which are due, not to structural, but to functional or, perhaps, rather nutritional changes in the cortex, viz.: paralysis agitans and chorea, which have a certain kinship to one another, the former being commonly hemiplegic in its mode of commencement and extension, while

[1] Glasgow Med. Jour., Feb., '97.

the other is frequently hemiplegic in its distribution throughout its entire course. In the case of chorea the abnormal movements are so obtrusive in comparison with the others that there is danger of the latter being overlooked, although weakness, at any rate, is now generally known as a frequent symptom. In exceptional instances weakness may be practically the only symptom, and the diagnosis may then be somewhat difficult. The age of the patient, the limitation of the weakness to one arm, and the occasional manifestation of slight choreic movements in the affected limb or in other parts may furnish the necessary clue.

Sheffield[1] describes a very acute attack of chorea in a girl of 10, in which—in addition to severe movements of the head, neck, and arms, and sometimes of the trunk and lower extremities—the ciliary muscles were affected. The pupils dilated and contracted repeatedly each minute, from the size of a pin-head until the iris was almost invisible.

Etiology.—Sinkler[2] concludes that the majority of cases depend upon some distinct and positive cause which careful investigation will usually discover. It is essential, therefore, in every case to determine the existence of a cause, and to take measures for its removal.

Reyerson,[3] calling attention to the fact that headache arises oftentimes from errors of refraction and muscular insufficiency, suggests that it is only a step farther to admit that severe manifestations of nerve disorder, including chorea, may be caused by the same irritation. His contention is, in a measure, substantiated by the fact that one case that came under his own observation exhibited $3\,^1/_2{}^\circ$ of right hyperphoria, and which recovered after partial tenotomy of the right superior rectus.

Tompkins,[4] noting that most authors designate fright or some of the emotions as the chief exciting cause, insists that the predisposed chorea is usually started by some reflex irritation, such as eye-strain, nasal irritation, tight prepuce, a bound-down clitoris, or lumbricoid worms; and secondary attacks may not always be true chorea. Likewise he pertinently divides chorea into two classes: those that tend to get well under almost any or even without treatment, and those who fail to get relief from any medicine. Both are based, as a rule, upon a well-marked neuropathic or tubercular predisposition. The percentage of hypermetropia, usually latent, he believes is extremely large, apparently about 70 per cent.; and an investigation for latent heterophoria should always be made, in choreic subjects, with the greatest care and patience. Finally, he notes that the spasmodic movements which accompany and indicate organic lesions of the brain—as, for example, those of leptomeningitis—exist in but a small proportion of choreic subjects, and are usually associated with other evidences of disease.

Legay[5] affords some interesting statistics relative to the origin of chorea, which he believes occurs only in those possessed of neurotic heredity with almost always a recent infection. This infection in the majority of cases is rheumatism, but there are many instances of the disease arising from other conditions, more particularly those of specific character.

Simon,[6] while noting the fact that chorea is much more frequent in girls

[1] Amer. Medico-Surg. Bull., Nov. 14, '97.
[2] Amer. Jour. Med. Sciences, May, '97.
[3] Canadian Prac., Jan., '97.
[4] Amer. Jour. Obst., Mar., '97
[5] Thèse de Paris, '97.
[6] Med. Press and Circular, Apr. 7, '97.

than in boys, and that this is one of the arguments invoked in favor of the nervous nature of the malady, believes it is nothing else but one of the numerous manifestations of rheumatism for the following reasons: It affects the same geographic distribution; like rheumatism, it is most frequent in cold countries; it shows its preference for damp seasons; besides, if choreic patients are examined with care, it will be found that cardiac affections are frequent, even though they may not have had rheumatic antecedents. One of the arguments against a rheumatic origin is that the disease is not modified by sodium salicylate, but this same drug is equally ineffective as regards endocarditis, cutaneous eruptions, etc. Beyond all doubt the origin of chorea is rheumatic in most cases.

According to Marfan,[1] the predisposing causes are age (from 6 to 15 years) and alcoholic or arthritic nervous heredity; the exciting causes are infectious diseases. Chorea is nearly always secondary to acute articular rheumatism, or to some infectious disease, such as influenza, measles, typhoid fever, scarlatina, and chicken-pox; or to chronic bronchitis with, probably, tuberculosis; to boils on the nape of neck, cervical adenitis, febrile dental periostitis, impetigo, suppurating otitis media, and endocarditis or pericarditis. An efficient part is played by the mental emotions. In 19 of 76 cases he found no family history of disease, but suspected an unobserved previous infection. In 14 cases he found cardiac lesions, and in 6 of the 14 the chorea was unmistakably of rheumatic origin; further there is an etiological identity between chorea and endocarditis.

Krafft-Ebing[2] states that chorea is oftener seen in adults than was formerly thought, and that in them it possesses a different significance. Again, the proportion of female to male cases is as 3 to 1. It is not always hereditary, and may be result of rickets, and even of severe fright. Among the actual determining causes he places febrile diseases with pain, and notes that in England the connection between acute rheumatic affections and chorea is very close. Endocarditis, *per se*, he will not admit as a cause, though it may frequently be an accompaniment.

Guck[3] describes two cases of what he terms "rheumatic chorea" in which heredity was very apparent. None of the ordinary drugs were of benefit, but sodium salicylate gave relief.

Meyer[4] points out the close connection which exists clinically between chorea and rheumatism. In a fatal case of chorea a considerable number of pyogenic cocci were found in the blood and in various organs, including the brain, being the same micro-organisms discovered in the pathological products of acute articular rheumatism; thus it is possible that these cocci are the connecting-link in the etiology of chorea and rheumatism.

Napier[5] details six cases, all in young women of ages varying from 17 to 21, in which the disease was very grave, and proved fatal in two. He noted the previous association of scarlatina or rheumatism—articular, endocardial, and præcordial—in every case; likewise recurrence of chorea on the same side as the former rheumatic affection had existed; also the presence of actual mania which in its acuteness seemed

[1] Rev. Mens. des Malad. de l'Enf., Aug., '97.
[2] Allg. Wien. med.-Zeit., B. 111, '97.
[3] Amer. Medico-Surg. Bull., Nov. 14, '97.
[4] Jahrb. für Kinder., vol. xl, '97.
[5] Glasgow Med. Jour., Feb., '97.

proportionate to the violence of the muscular movements.

Cornell[1] cites a case of paralysis and chorea as a sequel to scarlet fever. That the scarlatinal attack bore a causative relation to the growth of the nervous condition, he thinks, there can be no doubt.

Priestley[2] queries whether chorea should be considered a sequel of scarlet fever or not. Cheadle recognizes it as such, but qualifies the opinion by adding that in 1894 and 1896, 8360 cases of scarlet fever were under treatment at the Northeastern Hospital, and of these 5355 were completed there. Thirteen cases of chorea were observed, or 1 in 412 completed cases. Osler found 1 case of chorea to every 180 patients. Hence it would appear that chorea is less frequent among scarlet-fever patients than among patients in general. Of Osler's 13 cases 5 had rheumatic manifestations, which, in each instance, immediately preceded, or appeared simultaneously with, the chorea. Rheumatism or joint-affection which occurs as a complication of scarlet fever sets in toward the end of the first week; but in these cases it was considerably later, indicating a difference in the nature of the joint-affection.

Churton[3] read a paper before the Medical Society of London in which he took the ground, as the result of a study of 600 cases, that the toxin of chorea may be a glycocin, for which reason micro-organisms will not be found in the blood. No light has been thrown upon the connection of arthritis and chorea nor any explanation advanced why the toxin settled in the brain when chorea occurs in rheumatic individuals. He has failed to find any cases of rheumatism caused by fright or any of chorea primarily induced by chill.

Sanson[4] denies that arthritis and chorea are two manifestations of the same morbid process.

Bishop[5] believes an unstable condition of the higher nerve-centres predisposes to the condition, and that a poison affecting these centres might produce in one person epilepsy, in another general neurasthenia, and in a third chorea.

Dakin[6] reports seven cases of pregnancy complicated by chorea. While it is not common among pregnant women, it is a grave complication when present, and is itself modified by the fact that pregnancy exists; is also much more fatal; and mania is often present. Chorea is most frequent in first pregnancies and in young women. It usually appears during the first six months, the worst occurring at the second, third, and fifth months. A mitral murmur is present in all cases.

Mosler[7] describes a form, which he terms "alcoholic," occurring in adults with symptoms very similar to those of the ordinary form; the movements cease during sleep, although sleeplessness is a prominent symptom. The mind remains clear.

Massalongo[8] cites two cases that seem to corroborate Mosler: one in a man, aged 23, whose mother was hysterical and his father an alcoholic, who suffered from bilateral chorea with athetosis; the other a boy of 13, whose malady he terms *"Corea spasmodica congenitale."*

Mei[9] studied choreics bacteriologically, and discovered a lanceolate encap-

[1] Medicine, Jan., '98.
[2] Brit. Med. Jour., Sept. 25, '97.
[3] Med. News, Dec. 4, '97.
[4] *Ibid.*
[5] Canadian Prac., Nov., '97.
[6] Practitioner, London, Dec., '97.
[7] Med. Rec., Feb., '97.
[8] Policlinico, Feb. 5, '97.
[9] Gaz. degli Osp. et delle Clin., Aug. 22, '97.

sulated diplococcus extremely pathogenic to guinea-pigs, in which it determines an hæmorrhagic hyperæmia with diminished fibrin and no œdema. The histological lesions in the nervous system of patients and in the viscera of the guinea-pigs showed that the effect was more toxic than septic, with an elective action on the vessels. His findings appear to sustain Leroux's theory that chorea is a syndrome determined by some infective or toxic agent on a soil prepared by an inheritance of neurotic and arthritic tendencies.

Burr,[1] after studying about forty cases, finds that the blood is rarely absolutely normal in amount of coloring matter and number of red corpuscles during an attack. There is usually a moderate diminution in the hæmoglobin and a relatively slighter decrease in the number of red corpuscles; in other words, the anæmia is chlorotic in type. There is no relation between the severity of the anæmia and that of the attack, and when the latter is profound there is usually some complication competent to explain it. Anæmia is not an immediate, direct, exciting cause, but frequently a predisposing one.

Loudon[2] defines three groups, each having special blood-characteristics. The first he calls the plethoric group, and in these the patients are well nourished and of healthy appearance, but blood-examination shows some leucocytosis, and the acid-stains are not well taken up. The second group includes the anæmic cases, which are ill nourished, of unhealthy anæmic appearance, and to which a history of rheumatism frequently obtained, — *morbus cordis* is often present; in these a great lack of staining power is shown by the red corpuscles; macrocytes and microcytes are observed, and also poikilocytosis. The third group is made up of what he describes as the tetanic cases. In this group the movements are incessant during waking hours and very severe; articulation is defective, swallowing difficult, and there is a tendency to formation of bed-sores. One case of this latter description showed marked alteration in the blood and a tendency to disintegration of the red corpuscles. He holds that a case is grave and intractable in direct proportion to the alteration of the blood. Nearly all the cases show blood-changes and leucocytosis. In a few cases he observed marked increase in the amœboid movement of the white corpuscles, and thinks he has noticed a diminution of the eosinophile or orthophiles among the white corpuscles. He finds that in all cases the condition of the blood is of great importance in establishing a prognosis. He points out, in conclusion, that in the further study of chorea its hæmatology is of the greatest importance, and is of opinion that the clinical aspects of the disease point to an infectious origin.

Adult Chorea.—Facklam,[3] in a case of chronic chorea that died, found atrophy of the brain, pachymeningitis, leptomeningitis, recent hæmorrhages in the cortex and subcortical medulla, endarteritis, and diminution of the number of tangential fibres. He concludes that "Huntington's chorea" is something quite apart from the other forms of chorea, inasmuch as it manifests itself in somatic and psychological symptoms, may be inherited, and progresses very slowly; in its course it is accompanied by degeneration. Chronic periencephalitis is most probably the cause.

Collins[4] also studied Huntington's

[1] Pediatrics, Feb. 1, '97.
[2] Clin. Med. Record, Dec., '97.
[3] Archiv f. Psychiat., vol. xxx, Part I, '97.
[4] Med. Rec., Nov. 20, '97.

chorea and discovered that the reports upon its pathology are not uniform. In a case that he saw, the movements were very severe and incessant except during sound sleep, and even then they often caused awakening. The disease was fatal, and traceable to the maternal grandfather, who had three children, two of whom were affected with the disease, one of the two being the mother of the patient. At the post-mortem the dura was found considerably adherent, the diploë dense, and the Pacchionian depressions marked; the brain had a wet appearance, and the pia was not adherent. The convolutions of the anterior pole of the brain were very small, and the entire encephalon weighed forty-three and one-half ounces. The macroscopical changes were: thinness and atrophy of the cortex; mottled, streaked appearance and cribriform condition on cross-section in the fresh state, due to diminution in number and health of the ganglion-cells and to the increased perivascular and pericellular spaces and increased patency of blood-vessels. The microscopical changes were: decay or slowly-progressive degeneration of the ganglion-cells of the cortex throughout the brain, especially of the two deepest layers, the layers of large pyramidal and polymorphic cells, —this cell-death was particularly evident in the Rolandic region, very much less so in the anterior pole of the brain, and incomparably less in the posterior pole; increase of glia-tissue, but not sufficiently prominent to constitute sclerosis, the conspicuous increase being about the blood-vessels and ganglion-cells; enlargement of the pericellular spaces and distension of the perivascular spaces; slightly-diseased blood-vessels, consisting principally of a proliferation of the nuclei of the adventitia and a thickening of the intima (this involvement of the vessels was not regular or symmetrical, but showed itself in certain sections of vessels only); relative paucity of the medullated fibres of the cortex. In short, it may be said that the lesion was a chronic parenchymatous degeneration of the cortex, with consecutive and secondary changes in the interstices, the brunt of the disease having been borne by the motor regions; there was, in consequence, a degeneration of the pyramidal tracts in the spinal cord. In a case of Dana's the central convolutions suffered most, and the process occurred in patches throughout the affected cortex. There was nothing to justify the opinion that it is an inflammation; on the contrary, the process is evidently one of degeneration.

Krafft-Ebing[1] has seen three cases of senile chorea, of which Charcot, in all his wide experience, only observed four. It is due to alterations in the cerebral cortex, is very fatal, and usually runs its course in less than a year.

Bondurant[2] cites a case of chorea, developing at age of 18, following childbirth, associated with progressive dementia, athetoid movements of upper extremities, and spastic paralysis. Death from gangrene of the lungs at the age of 27.

Stanley[3] reports two cases of chorea coming on at the ages of 34 and 23, in a sister and brother, respectively. No other member of the family ever exhibited a similar affection.

Riseman,[4] says that, compared with its frequency in childhood, chorea is rare in advanced life; he chronicles a case in a German aged 75 years. Ex-

[1] Allg. Wien. med.-Zeit., B. 111, '97.
[2] Alien. and Neurol., July, '97.
[3] Birm. Med. Rec., Dec., '97.
[4] Amer. Jour. Med. Sci., Aug., '97.

posure to cold draughts is given as the cause.

Treatment.—Overend[1] has tested arsenic and belladonna in 25 cases. Large doses of arsenic have a beneficial influence in subduing the movements, and this is best seen after they have existed for some time. The drug should be given after food, and the patient should lie down for half an hour afterward in order to avoid retching and nausea. One girl, 10 years old, received 70 grains of extract of belladonna daily: 1000 grains in twenty six days. Another received 37 grains of atropine in eighteen days. During the administration neither fever, rash, nor erythema was noted, but the pulse became quick and the urine scanty. In 2 instances indistinctness of vision was observed; 4 suffered from sickness and diarrhœa. There was no dryness of throat, no headache, and no delirium. In 2 belladonna was useless; in the remainder its efficacy was noteworthy. It appears to be most beneficial in recent seizures, and its influence is sometimes very marked in severer forms; it makes itself felt after about four days. Should no visible improvement occur before the tenth day it is useless to continue it. It is perfectly justifiable to give to a child as much as 30 minims or more of tincture of belladonna every four hours for ten days, or even longer, but certain precautions are necessary. The patient should be kept in bed and the urine measured daily; small doses of potassium acetate may be added if it becomes much diminished or if the eyelids show puffiness. In one child nocturnal incontinence occurred and the dose was lessened. As soon as the movements become trivial or occur only during exertion, it is better to omit the belladonna, to begin massage of the affected muscles, and to administer cod-liver-oil and syrup of phosphate of iron or other tonics. In obviously-rheumatic cases arsenic in large doses may be given a trial, or may be combined with belladonna from the first; it may be continued a week or longer without intermission.

Grancher[2] recommends living as much as possible in the open air and gymnastic exercises. Antipyrine and Boudin's solution of arsenic are the only drugs employed, and the action if the former is certain in that it shortens the duration of the disease. Boudin's solution exerts the same precise influence, only in a more pronounced manner; but it requires careful and discriminating handling, otherwise very serious mistakes may be made. Recovery does not take place until intolerance is shown by loss of appetite, vomiting, and diarrhœa; when these symptoms appear, the amount should be gradually diminished, but after they have disappeared, the progressive doses should be repeated. Recovery usually takes place within eight or ten days, but even then the treatment must not be suspended, but the arsenic solution gradually diminished until complete suppression is reached.

Marfan[3] recommends mental and physical rest and maximum doses of antipyrine and arsenic, in the same way as suggested by Grancher; he completes the treatment by the use of some hypnotic, and during convalescence prescribes gymnastics and sulphur-baths.

Renai[4] has confidence in only three remedies: absolute rest, avoiding any external excitation whatever, and placing the patient in a dark room; a gentle ascending electric current along the

[1] Lancet, London, July 31, '97.
[2] Independ. Médicale, June 3, '97.
[3] Rev. Men. des Mal. de l'Enf., Aug., '97.
[4] Gaz. deg. Osp. delle Clin., Aug., '97.

spine, progressively increased; arsenic in large doses, commencing with twenty drops of Fowler's solution each day for children, and double this amount for adults. When the chorea ceases, the treatment should be continued for some time, as the disease readily returns. Nutrition should be carefully looked after, and gymnastics are useful.

Spiller[1] reports a case of paretic chorea, in a child 10 years of age, the movements a little more violent on the left side; in the lower limbs and face very slight. She was put on proper diet, her mode of life regulated, and Fowler's solution given in ascending doses. Improvement was rapid, and within a few weeks the paresis and choreic movements had disappeared.

Sinkler[2] regards the general health as of first importance. Tonics, especially chalybeates, should be administered, and, if possible, change of air obtained. Arsenic, to be of value, must be administered in gradually-ascending doses until some toxic influence is observed. Many cases which are not relieved by internal administration are cured by arsenic hypodermically. Much benefit will be derived from offering a premium whenever the movements are controlled for a certain length of time. The most speedily beneficial results are obtained by a modified course of rest treatment.

No routine treatment can be followed, states Tompkins.[3] The first indication is to remove everything that may be an irritating cause. The patient should be taken from school; if the prepuce is too long, it should be cut off; if there is evidence of worms they should be got rid of, etc. The percentage of hypermetropia, usually latent, he believes is extremely large, perhaps fully 70 per cent.; and an investigation for latent heterophoria should always be made with the greatest care and patience. The relief of marked heterophoria should be finally attained only by graduated tenotomies upon the muscles exhibiting abnormal tension or by advancement of the tendons exhibiting defective power. Prismatic glasses are not curative and should not be given for constant use. Choreic subjects are usually rapidly cured by eye-treatment alone; the eye-problems encountered, however, are not, as a rule, so complicated and difficult to solve as those of epileptics. He employs sodium bromides with Fowler's solution of arsenic, and, if there is a chance of malaria being a factor in the trouble, gives quinine also.

Lewis[4] has given arsenic so often in chorea that he has grown to look upon it as a safe remedy in childhood. Ten drops of Fowler's solution, three times daily is not a large dose, and is often exceeded, not only without harm, but with decided benefit.

Collier[5] saw a pregnant woman, aged 21, who suffered from chorea, which chiefly affected the head, face, and right arm. She was at once given Fowler's solution, increased, after a few days, to 10 minims, thrice daily. Seventeen days later the doses were doubled, but had to be permanently discontinued a few days thereafter because of the erythematous rash it induced. The movements now became more marked and she was unable to obtain any rest without sedatives: chloral, bromides, morphine, sulphonal, chloroform inhalation; the free use of alcohol was tried, but she became worse. At times she became mentally excited and maniacal. After twenty-six

[1] Phila. Polyclinic, Aug. 28, '97.
[2] Amer. Jour. Med. Sci., May, '97.
[3] Amer. Jour Obst., Mar., '97.
[4] Phila. Ped. Soc.; Med. and Surg. Reporter, '97.
[5] Bir. Med. Rev., Oct., '97.

days she began to exhibit symptoms of exhaustion. Abortion was now induced, a five months' fœtus delivered, and the uterus thoroughly washed out with a strong solution of iodine. The patient made a rapid recovery. There is no doubt in the mind of the author that the abortion saved her life.

Krafft-Ebing[1] lays stress upon the attainment of "peace of mind and body." A meat diet is contra-indicated, and the patient should be out-of-doors as much as possible. He inveighs against the use of electricity, but recommends warm baths. In severe cases sleep may be induced by means of the wet pack; if hypnotic drugs are called for, he prefers amyl hydrate, trional, urethan, and, in the worst cases, chloral hydrate. In treating the general condition he states that nothing approaches arsenic for allaying the irritability of the nervous system, though nux vomica is often of service. Chorea in adults of over thirty years comes on slowly, is difficult to subdue, and its victims often develop *tædium vitæ* and suicidal impulses. In one case of this kind it was found that hyoscine acted with benefit for a time, but later on the disease progressed.

Bishop[2] gives attention to bowels and diet, the securing of proper food, etc.; also employs static electricity and inhalations of ozone.

Marfan[3] says the three great remedies are rest, antipyrine, and arsenic.

Admitting—and it is generally accepted to-day as a fact—that the choreic movements are due to hyperæmia of the superior portion of the cord, says Simon,[4] it is rational to apply each day dry cupping to the neck. Aconite is a valuable remedy, and, when the patient is much agitated, bromides, chloral, and the warm bath are useful. In the second stage antipyrine appears to be the best remedy in every case, and, properly administered, is without danger,—even children bear it well,—and alike diminishes the duration of the malady and the intensity of the movements. Ten grains should be given at the outset three times a day, and gradually increased until double the amount can be ingested. During the period of decline, tonic *régime*, warm salt-baths, gymnastics, and arsenic and phosphate of lime, alternately, are to be insisted upon.

Rodman,[5] speaking of those rare cases of facial neuralgia with chorea of the opposite side, believes that intracranial neurectomy is the only reasonably certain method of relief.

Adams[6] chronicles a case of choreic embolism, in a boy aged 8 years, which recovered after four months under the exhibition of potassium iodide, aided by rest in bed and good, rich food.

DYSMENORRHŒA.

Etiology.—Parsons,[7] during ten years' experience, had never met with a case of membranous dysmenorrhœa nor seen one in the practice of his colleagues; it appears to be a pathological curiosity. The spasmodic neuralgic form without any pathological lesion is also extremely rare. Unmarried women who are not anæmic should, if necessary, be examined under an anæsthetic, and the probability is that some lesion will be found to account for the dysmenorrhœa. A great number of cases occur in anæmic young women, and full doses of iron will cure the anæmia, and with it the dysmenorrhœa. The worst cases are usually due to anteflexion, and in many

[1] Allg. Wien. med.-Zeit., B. 3, '97.
[2] Canadian Prac., Nov., '97.
[3] La Sem. Méd., July 30, '97.
[4] Med. Press and Circular, Apr. 7, '97.
[5] Amer. Prac. and News, June 12, '97.
[6] Ann. Gyn. and Ped., Jan., '97.
[7] Brit. Med. Jour., Oct. 24, '97.

of them the sound will not pass until the uterus is straightened. The patients themselves state that after hours of agony (presumably from contraction of the uterus) they pass some clots, and are immediately relieved until their next period. He very much doubts the ovarian origin of dysmenorrhœa, to which the formation and growth of an ovarian cyst did not give rise. There is no scientific proof that the ovary *per se* ever causes dysmenorrhœa. When no lesion can be found, the fault is probably in the nervous system, and to this attention must be directed. Fibroma not infrequently causes dysmenorrhœa, even in women under thirty years of age. The tumor may be very small and escape notice unless a careful examination is made under an anæsthetic. For these cases the negative pole of the constant current, in mild doses every other day, is of great benefit.

Williams, of Cardiff,[1] calls attention to the co-existence of painful menstruation and acute anteflexion of the uterus. The class of patients who suffer from this type of disease are usually, if married, sterile, and the supervention of pregnancy often effects a cure; the pain which they suffer is colicky in nature, felt chiefly in the hypogastric region, and dates from puberty. Pelvic examination reveals the absence of any inflammatory lesion; the uterus bobs up and down on the examining finger with great mobility, and is sometimes displaced backward, sometimes to one side. The degree of anteflexion may be in excess of normal, but still not be pathological. The pain is probably due to irregular abnormal contractions, set up by a diseased condition of the mucous membrane at the seat of flexure.

De Leon[2] combats the obstruction theory of dysmenorrhœa, and divides the malady into dysmenorrhœal endometritis and uterine spasm. The first includes all forms in which there is any local mechanical obstacle; all others are uterine spasm, which he regards as affecting the sphincter of the uterus; that is, the cervix. Of 167 patients observed 37 complained of painful menstruation; in 32 a local cause was discovered, but in 5 virgins the affection was spasmodic; besides, there were 21 who had manifest stenosis without painful menstruation. Among those subjected to curetting there were 17 with dysmenorrhœa, but only 1 had marked stenosis. Stenosis may be due to swelling of the mucous membrane occurring only at the period of menstruation, and consequently not noticeable at other times. Diseases of ovaries and Fallopian tubes may be a cause; so may heredity. In one family where 2 daughters suffered with dysmenorrhœa, a son had dyspepsia and the father was a drinker; in another family 3 girls had dysmenorrhœa, a boy had nervous dyspepsia and headache, and the father was not a drinker.

Treatment.—Cameron, of Glasgow,[1] considers the spasmodic variety by far the most common, as there is frequently little to be detected beyond the symptom of severe spasmodic pain. Some relief may be obtained by sedatives externally or internally, but there is always danger of setting up an opium or chloral habit. It is better to dilate the uterus, either by tents or solid instruments; but the use of tents is not free from danger, both from sepsis and from fracture or tearing away of a piece of the tent upon extraction. To effect rapid dilation the solid dilator, well regulated, is preferable. The uterus can be

[1] Brit. Med. Jour., Oct. 24, '97.
[2] Centralb. f. Gynäk., July 17, '97.

easily secured by the vulsellum forceps if a sound is previously introduced into the cavity, and a series of dilators can then be passed rapidly, with the result that the patient is relieved, at least for some months.

Martin, of Birmingham,[1] says the causes of dysmenorrhœa may be either extra-uterine or intra-uterine, and the treatment differs markedly in the two classes of cases, for what will relieve in the one may prove worse than useless in the other. Three factors are concerned in the production of the pain of dysmenorrhœa, viz.: (1) contraction of the muscular fibres of the uterus or Fallopian tubes; (2) increased spasm; or (3) blood-pressure in the tissues or uterus or appendages,—congestion the cause. Nearly all are benefited by rest at the periods, hot vaginal douches during and between the periods, and, in inflammatory cases, tampons of glycerin and ichthyol, and saline aperients. Morphine and alcohol will give great relief, but must never be recommended; the administration of alcohol to young women at such times is to be blamed for much of the secret drinking that prevails. The drugs most useful are bromides and belladonna, antipyrine, and cannabis Indica, and both viburnum prunifolium and viburnum opulus. Operative measures should only be resorted to when other and less severe remedies have failed. In cases due to spasmodic contraction of uterus or stenosis of cervix (if there be no signs of extra-uterine disease) dilatation is often of some service, but is seldom of more than temporary benefit. In cases due to chronic peritonitis, binding down and matting together the uterus, ovaries, and tubes,—cases in which the ovaries are cystic and the tubes perhaps occluded, and the uterus retroverted and adherent to the rectum,—very marked and permanent benefit results from a "conservative operation" on the appendages. Here it is best to free the uterus, ovaries, and tubes from the adhesions, and after ignipuncture of the cystic or sclerosed ovaries fix the fundus forward to the anterior abdominal wall. In grave and otherwise incurable lesions of appendages, such as abscesses of the ovary or pyosalpinx, the removal of the diseased organs is strongly indicated.

Williams[2] thinks rest in bed and saline aperients are of very little value. Better results are obtained by the use of nitrite of soda combined with a diffusible stimulant; but for obvious reasons such a treatment cannot be followed month after month. Dilatation is successful to some measure; that is to say, the pain is kept away from three to six months, but returns later. Dilatation performed a second and third time yields slightly better results, but never results in complete cure.

Routh, of London,[3] thinks dysmenorrhœa should be regarded as a symptom associated with many other constitutional or local symptoms, and the whole group of symptoms treated, tracing all back to the main constitutional or local *origo mali*, of which the dysmenorrhœa is simply a solitary evidence. He first treats the constipation, the anæmia, or other constitutional state, and then, if need be, examines per rectum, and, if the perimetrium is involved or the ovary enlarged, their state is attended to. As a rule, antispasmodics are very beneficial. The best of these are phenacetin (two doses being usually sufficient), antipyrine, or nitroglycerin ($^1/_{100}$ grain). Locally a glycerin and gelatin pessary.

[1] Brit. Med. Jour., Oct. 24, '97.
[2] *Ibid.*
[3] *Ibid.*

If these simple measures fail, then, and then only, should any local treatment be adopted, dilatation being often of great value.

Lycett, of Wolverhampton,[1] considers that, in the absence of local cause, it is important to investigate the past and family history of the patient. In the rheumatic diathesis he has found the administration of black cohosh and allied remedies advantageous. Struma is often an associate, if not an etiological, factor.

Fenwick, of Soho,[2] says that very many cases are due to congestion caused by constipation or otherwise, and improved by scarification and saline purgatives, especially sulphate of soda. Too great benefit has been attributed to dilatation, the effects of which on the cervical canal completely pass away in an hour or two; there is no doubt that constitutional taint, and especially the rheumatic diathesis, is an important element in a very large number of cases.

Byers, of Belfast,[3] attaches great importance to the personal equation in patients. Each case has to be treated by itself. In some, attention to such conditions as anæmia, the rheumatic element, or constipation will cure the ailment; in others dilatation, done with the strictest antiseptic precautions; while in many simple cases in unmarried women attention to the nervous system and an endeavor to make the patient less introspective, and by bicycling, or some occupation to direct her mind away from her painful pelvic sensations, will frequently bring about a complete cure.

Kerr, of Glasgow,[4] is prepared to admit that in time the cervical canal returns to the narrowed condition that existed before dilatation, but he is satisfied that very distinct benefit results for some time, perhaps for a few months. But dilatation is not always, nor in the majority of cases, the best treatment. In nervous cases he has seen very considerable benefit from treatment by electricity, either by the continuous or faradic current.

Connel, of Peebles,[5] calls attention to the fact that in sterile married women prescription of abstinence from marital relations for longer or shorter time, followed by free dilatation immediately before their resumption, will often prove successful; such was the case in three instances where sterility had existed for from three to five years. He believes in the advantages of bicycling; and if growing girls, especially when anæmic, were systematically encouraged to practice this exercise in moderation, we should, by and by, have less of spasmodic dysmenorrhœa.

Purslow, of Birmingham,[6] says dysmenorrhœa is often met in women in whom the first few years of menstrual life was free from pain, and in whom, therefore, it cannot be due to congenital conditions, but is probably of neurotic origin. He strongly deprecates local examinations or mechanical treatment unless good was likely to be done; it is a great misfortune for a young unmarried girl to get the idea that she has something "wrong with her womb," and he would rather advise that she should be encouraged as much as possible not to dwell on her symptoms.

Cadell, of Edinburgh,[7] thinks that dysmenorrhœa seldom occurs at puberty except in cases of an infantile uterus, and is due to some cold or overexertion, easily cured if taken in time, but, if neglected, extremely intractable. Neither alcohol, morphine, nor even the bromides should be prescribed. The mind

[1] Brit. Med. Jour., Oct. 24, '97.
[2] *Ibid.* [3] *Ibid.* [4] *Ibid.* [5] *Ibid.* [6] *Ibid.* [7] *Ibid.*

ought, if possible, to be diverted from the uterine condition, and bicycling or any work or amusement that will take the patient out of herself may be useful.

Cameron[1] refers to the marked increase of dysmenorrhœa resulting from too common custom of using preventatives against conception.

The best treatment preceding the flow and associated with a movable uterus is, according to Langstaff,[2] the injection of 10 minims of a 3-per-cent. mixture of Churchill's tincture of iodine and water into the uterine cavity every four or five days during the intermenstrual period. The injection is effected by means of a fine glass tube, curved an inch from the end and expanded into a funnel shape at the other; a piece of sheet rubber covers this end, and by the pressure of the finger the contents are passed into the uterine cavity. The majority of the cases treated by him in this way were unmarried, and had previously required opiates. The treatment has no effect when there is pelvic inflammation or disease of the ovaries and tubes.

De Leon[3] remarks that, of 17 sufferers from dysmenorrhœa, 8 were completely cured by curetting; 7 of the remaining 9 returned with a relapse of the old trouble; 2 received absolutely no relief. If investigations warrant the theory of spastic contraction, high amputation of the cervix should be performed. In one case of dysmenorrhœa and sterility Schröder's conical excision of the cervix did away with both complaints.

EPILEPSY.

Treatment.—Chas. B. Stockwell[4] cites the case of a boy, 3 1/4 years old, who developed severe attacks of *grand mal.* At the end of the second month the paroxysms had assumed the *petit-mal* type, and became very frequent, as many as from seven to twenty-five seizures occurring in a single day. Repeated examination showed no reflex source of these convulsions. He was at first given bromide of ammonium, 4 grains; antipyrine, 1 grain; and Fowler's solution, 1/2 minim, twice daily. Under this treatment the convulsions were increased. The treatment was then changed to bromide and iodide of sodium, of each, 3/10 grain; antipyrine, 1/3 grain; and fluid extract of horse-nettle, 10 to 30 minims. Like the other treatment, this caused no lessening of the convulsions, and it was decided to try horse-nettle alone. Accordingly, he was put on a fluid extract of the berries and root prepared by Parke, Davis & Co. The dose was gradually increased until 1 ounce of the preparation was given three times a day. During part of this time a fluid extract of the berries alone was used, but later a preparation of both the berries and root, which was increased to 12 drachms four times daily. This was followed by a cessation of the spasm, but the gait became unsteady and there were pains in the muscles of the thighs and legs. These effects were attributed to the drug and to the contained alcohol, which in the preparation amounted to about 60 per cent. Later a fluid extract was prepared of the root alone, which proved more satisfactory than the other extracts. It was well borne by the stomach and seemed to have a more specific effect in preventing the epileptic seizures. At the end of a month the paroxysms had entirely ceased; but the drug was continued in diminishing doses for three or four months and then withdrawn. At the

[1] Brit. Med. Jour., Oct. 24, '97.
[2] Brooklyn Med. Jour., May. '97.
[3] Centralb. f. Gynäk., July 17, '97.
[4] Med. Age, Aug. 25, '97.

end of thirteen months there had been no return of the attacks.

HYDROPHOBIA—RABIES.

Prophylaxis.—G. Archie Stockwell,[1] in a lengthy article on this subject, concludes with a few simple axioms, which, if heeded, will, in the majority of cases, allay fear and quell the senseless epidemics of rabiphobia that threaten from time to time:—

Rabid dogs do not fear, but court, water.

Rabies can never arise spontaneously either in animals or man; the absence of recent wounds upon and the good health of the creature inflicting the bite are alike evidence of the non-specific character of the disease.

Wounds inflicted by the teeth of non-carnivorous creatures are never rabic, though a blood poisoning may be induced; man cannot communicate the disease to other human beings or to animals.

The saliva of truly rabid carnivora alone is capable of inducing rabies.

Excessive saliva in any creature, more especially dogs, is always induced by any affection of the mouth or throat; it is the universal sequel of toothache, of inability to swallow from any cause, of paralysis, of throat-abscess. Paralysis independent of rabic condition is a sequel to numerous local brain and nerve maladies. Twitching of eyes, of eyelids, of lips, and muscles; lolling tongue, in-drawn tail, up-drawn flanks, drooping head, slinking gait—one and all should be included in the same category.

Safety lies in preserving life of the suspected canine and sequestrating for observation; by premature death the only evidence whereby rabies can definitely and with certainty be established is destroyed. Muzzle the creature and examine for recent wounds; if none is exhibited, fear is idle.

If a dog evinces a good appetite, and if it partakes of food freely on and after the fourth day, it is not rabid; if it dies without paralysis it is not rabid; if it succumbs to paralysis, the chances are still a thousand to one that its death was due to some natural cause; if it falls into convulsions and froths at the mouth, it is an epileptic and an object of commiseration; ninety-nine of every hundred dogs pronounced "mad" are epileptics or choreics, and dogs with "fits" are positively never rabid; if after ten days' confinement the suspected animal evinces a cheerful disposition, there is no danger whatever and it should be released.

When death supervenes, critical examination of the body—the brain, viscera, etc.—should be made by a careful, competent pathologist, to determine whether there is a cause for death *aside* from rabies.

Members of the human race suffering from rabies do not howl, whine, bark, or exhibit other canine characteristics or peculiarities any more than do cats, fowls, sheep, cattle, etc.; such phenomena are conclusive evidence the malady is—*hysterical*!

Intolerance of light and of moving air, fear of water and bright substances, and spasm of muscles of the throat and neck, far from constituting specific evidence, are common in diphtheria, croup, goitre, sore throat, lock-jaw, pregnancy, hysteria, ear-abscess, hay fever, and poisoning by certain mineral and vegetable substances; they may arise from the use of narcotics, sedatives, and alcoholics; from cancerous affections; certain maladies of the internal ear; or of the eye,

[1] Med. Age, Oct. 10-25, '97; Dom. Med. Mo., Dec., '97.

as in glaucoma; diseases peculiar to sex, and a multitude of brain and nerve maladies. In no instance would these symptoms excite special comment or alarm were not the dog linked therewith as a factor.

Error of judgment is the almost inevitable result of accepting mere negations for their antithesis; careful examination of the evidence laid down for the distinction of rabies reveals little aside from mere negations; until death ensues the weight of evidence is always negative; when dissolution follows, it is very far from being presumptive of the positive.

Since less than 3 per cent. of infected canines ever contract the malady, the danger to man is several hundred times less than from scarlatina, measles, quinsy, ague, and a host of simple maladies. As Charles Bell Taylor remarks: "It is less than one in a million—less than being kicked to death by a horse"; to which may be added: it is less than the gallows. Finally, after examining as thoroughly as possible the history of every case of rabies reported as occurring in North America during fifty years (and they number about one thousand), Stockwell has been unable to find even one that was not open to the gravest suspicion as to error.

Law[1] details a supposed case of rabies, diagnosed as such by every physician in Ithaca, N. Y., which, under a dose of castor-oil and a tonic, recovered within a week.

Smith, of Virginia,[2] states that rabies does not exist in his State, and that it will take better evidence than has yet been produced to convince him that it exists anywhere.

Dulles[3] has carefully studied rabies, or hydrophobia, from every stand-point for sixteen years. During two years he critically examined forty cases. He insists that rabies is not a specific disease, and that the term "hydrophobia" should, if employed at all, be used in the same sense as "convulsions" without prejudice as to the cause of the phenomena. There can be no doubt that death with a peculiar train of symptoms has often followed dog-bite; but these symptoms and the usual fatal issue are nowise peculiar to injuries inflicted by animals believed to be rabid. There are many cases in which the belief in the madness of the dog rests wholly upon the result in the person bitten, and it is not scientific to assume that this belief is more than a belief; and no person fit to discuss the question would treat it as a demonstration. Further, the symptoms appear in a great many diseases, and persons bitten by dogs enjoy no immunity from these diseases. Besides this, there are many cases in which persons have died of hydrophobia, while the dogs have survived. There are other cases in which the symptoms of hydrophobia have appeared after various traumatisms; and such a traumatism as is caused by a dog-bite may (without assuming the presence of a specific virus) lead to nervous symptoms and death. A curious factor in this connection is that dog-bites cause so many deaths in what may be termed the private walks of life, and practically none among men who are constantly handling large numbers of dogs, including persons who habitually take up stray dogs on the streets, such as dog-catchers, policemen (as in London), and attendants of such institutions as Homes for Lost and Straying Dogs. In the Home in London over 200,000 canines have been handled without a

[1] Proc. U. S. Vet. Med. Assoc., '97.
[2] *Ibid.*
[3] Proc. Med. Soc. of Pa., '97; Med. Age, July 10, '97.

case of rabies or hydrophobia; among keepers of kennels it is the same, though they may have been bitten several times, many of the wounds inflicted by dogs believed by their owners to be rabid. It is a remarkable fact, also, that, though there has been such a fever of excitement about rabies in Paris in recent years, there have been no deaths among dog attendants and "pound-keepers." If the bites received by the foregoing people could be counted, the customary ratio of deaths to bites would have to be enormously modified. The oft-quoted guess of John Hunter, of 1 to 24, would probably require to be exchanged for 1 to 75 or perhaps 1 to 100.

[Fabre says the ratio is less than 1 to 600. Ed.]

SCARLATINA.

Infection. — Ingersles[1] reports three cases in which scarlet fever began in solutions of continuity of the skin, the patients having been exposed to other cases of scarlatina. In one the virus was probably introduced through a paronychia and corresponding lymphangitis; in the other two wounds from burns furnished the points of entrance. The symptoms in all were characteristic, except as regards throat symptoms. He suggests that, if a careful examination of the skin were more frequently made in scarlatina with mild throat lesions, cases similar to these would be more frequent, a wound in the skin being easily overlooked.

Klein[2] has made a bacteriological study of the desquamating skin of persons at various stages of convalescence. At no stage of the peeling process after scarlatina has he detected in the cuticle any microbe which could (to quote) "be thought of as having concern in spreading the disease." The urine afforded a similar negative result.

Grasset[3] reports a case of scarlatina in a boy of $2\,^1/_2$ years, living in a district which had been free from scarlet fever for years. Investigation showed the source of infection to be a letter, received six days before the boy sickened, from the grandparents, announcing that a child living with them was convalescent from scarlet fever, and "shedding her skin," a few pieces of the latter being inclosed. The letter and its contents were used as a plaything by the boy until the day he sickened. Grasset refers to a report by Laurie of a German woman who wrote during convalescence from scarlet fever to two friends in France, both of whom subsequently developed the diseased and died.

Rotch[4] says scarlet fever is the most irregular of all the exanthemata in its virulence and in the manifestations which it presents in different individuals. The skin appears to be the chief vehicle of the contagion, which has a wonderful tenacity for clothing and other articles, and may be capable of reproducing the disease for many months. In contradistinction to measles, which is known to be highly infectious in the early stage, scarlet fever appears to be most infectious in the latter stages, and the contagium is most likely to be disseminated during the stage of desquamation.

Seitz[5] was unable to find either bacteria or protozoa as primary causes, and looks on streptococci as secondary invaders. The variability of the death-rate, so often mentioned, is very striking, as shown by the extremes of mor-

[1] Zeit. f. klin. Med., B. 31, '97.
[2] Brit. Med. Jour., Jan. 1, '98
[3] Ann. d'Hyg. Pub., vol. xxxiv; Centr. f. Bakt., Parasit., u. Infect., Jan. 9, '97.
[4] Boston Med. and Surg. Jour., May 27, '97.
[5] Munch. med. Woch., No. 3, '98.

tality in different years: 2.6 to 15 per cent. Season and weather have no definite influence on the frequency of complications. The local infectiousness of certain houses and rooms, and the family disposition, are often observed, as also the temporary individual disposition, many persons being affected only after several weeks' exposure. As to age, the first year of life shows the smallest morbidity. Most cases occur between the second and fifth years. Out of 833 cases second attacks were twice noted: once after one, and once after two years; in the latter the second attack was the more severe.

Coxe[1] declares scarlet fever in its relation to the health of the race holds first place, and the infection is probably confined to the period of scaling off. The scarlatinal virus surpasses any other eruptive fever except variola in its tenacity and portability. One of the most marked features of the disease is the predisposition which it entails to the incursion of pathogenic germs other than those believed to cause the disease itself, thus causing croupous inflammations, etc., as complications.

Prophylaxis.—Coxe[1] further adds that the most reliable method of prophylaxis is isolation of patients and nurses, and thorough use of disinfectants in their rooms and on their persons. All articles not absolutely needed should be removed from the sick-room, and no one except nurses and physicians allowed to enter. Constant ventilation should be insisted upon. Clothing used about the patient should, on removal, be placed in a tub of boiling water containing carbolic acid and sulphate of zinc, or in corrosive-sublimate solution, 1 to 1000, and allowed to soak at least an hour; then placed in boiling water for washing. Vessels used by the patient should have a disinfecting fluid constantly in them, and be cleansed with boiling water immediately after using. Water-closets should be disinfected daily with lime or sulphate of zinc. Sterilized cloths should be substituted for handkerchiefs, and burned after using. During desquamation the patient should be kept well anointed with carbolized vaselin or like material; the physician also should anoint his hands and face and put on a close-fitting gown and hood before entering the room, and wash and disinfect his hands and face and put the cap and gown in a bag containing a sponge saturated with formaldehyde before leaving the house. After convalescence, the room and everything which has been exposed should be thoroughly disinfected, and feather-beds and straw-beds, or other things which cannot be thoroughly disinfected, be burned. Formaldehyde is probably the best, safest, and cheapest disinfectant to use. The ordinary formalin may be evaporated by heat into a closed room, a pint being so used for every thousand cubic feet of space. Thus used it is more destructive to germs than any other disinfectant. That an outbreak of scarlet fever at Plainfield, N. J., was traced to the milk-supply is an editorial statement.[2] One of the employees with scarlet fever continued to assist in handling the milk.

Diagnosis.—Lindsay[3] summarizes the main points: initial vomiting, very constant in children under ten, less so above that age, and rare in measles, German measles, and diphtheria; undue frequency of pulse,—say 140 or 150,—out of proportion to the other symptoms; the rash, beginning on the upper part of the chest, over the clavicles, and

[1] The Sanitarian, August, '97.
[2] Med. News, June 26, '97.
[3] Brit. Med. Jour., Feb., '97.

about the flexures of the neck, often well marked on the backs of the wrists. To discriminate between scarlatina and German measles he is in the habit of relying on the following points: In scarlatina there is initial vomiting; a brief, but well-marked, prodromal stage, with vomiting, chills, headache, and sore throat; no rash on the face; fairly well marked constitutional symptoms; the sore throat sometimes going on to ulceration; no early enlargement of post-cervical glands. In German measles there is no vomiting, no prodromal stage, the rash being often the first symptom, and always appearing on the face; little or no constitutional symptoms; no ulceration of the throat; a very characteristic early enlargement of the post-cervical glands.

Rotch[1] says that a very important point, which is often of great aid in the diagnosis of a doubtful case, is distribution of the eruption characteristic of the disease. In true scarlet fever it first appears on the neck and thorax. There is also a general intense redness of the whole throat, including the hard palate. The entire mucous membrane is affected, and the small dots, which—in connection with the hyperæmic condition of the skin—represent the condition of a punctate erythema, from being localized on the moistened mucous membrane, have a little more darkened appearance than the adjacent reddened tissue. In measles, on the contrary, the mucous membrane of the throat has a blotchy appearance and is of a darker red than is seen in scarlet fever, while the mucous membrane between these blotches is but slightly congested in comparison with that of scarlet fever.

Lemoine[2] reports twenty-three statistical cases in which the eruption was exclusively limited to the face. The patients suffered from an angina, with fever and redness of the face. The fever fell, but the redness continued, and was shortly followed by a more or less abundant desquamation. A few of the cases afterward developed albuminuria, anasarca, and symptoms of uræmia. Probably a transition stage between the anginoid scarlatina and scarlatina with general eruption.

Symptoms.—Meyers[3] observed a clinical symptom which has, up to the present time, passed unnoticed, probably because scarlet fever is studied especially in children, who usually do not give very exact information regarding their sensations. This is a slight paralysis of the extremities. The patient may complain of not being able to move the hands or the feet, though this is exceptional, and was observed in one case only; more frequently it is only a numbness of the hands accompanied by a sensation of pricking or tingling; or the numbness may be absent and only the pricking or tingling sensation may be felt, localized in the palmar surface of the ends of the fingers or in the palm of the hand. This symptom is rarer in the feet; it is found in them at the same time that it occurs in the hands, or else separately. It appears during the eruption and quite frequently, at the same time with it, but exceptionally before it. Its duration is variable; it may be fugacious, lasting only a few minutes and then disappearing altogether. In the majority of cases it is of longer duration; it appears some hours or a day after the onset of the eruption, and persists for two or three days, usually with interruptions. It may also manifest itself at a later period, on the third, fourth, or fifth day of the

[1] Boston Med. and Surg. Jour., May 27, '97.
[2] Trans. Soc. Méd. des Hôp., Jan. 29, '97.
[3] La Press. Méd., March 5, '97.

eruption. Some patients do not present this symptom until they have occasion to use their hands; others present it on coming out of a cold bath or when they put their hands in water. The symptom is very constant, and was met with in seventy-nine of one hundred cases—these statistics relate to adults only; among children it was observed once accidentally in a boy 7 years old. The symptom also is not accompanied by any painful manifestation.

In cases of abortive scarlatina this symptom may aid in the diagnosis; it may also be of use in the retrospective diagnosis in patients who do not present the eruption and in whom desquamation is fugacious or very late. This symptom is absent in other eruptions.

Fussell[1] queries what is the condition of the tongue which is considered characteristic of scarlet fever, and what is the appearance of the tongue to which the term "strawberry" is applied? During the first three or four days of scarlet fever the tongue is white-coated, with the papillæ prominent, sticking out through the white fur, as if the organ had been sprinkled with red pepper. After the fourth day this coating disappears, — sometimes gradually, but sometimes quickly,—leaving the tongue of a bright, shiny red, with very prominent papillæ.

The first conditions, while common in scarlet fever, and while the redness of the papillæ is more marked in that disease than in any other, occur in many febrile affections, especially where there is irritation of the digestive tract; therefore they cannot be characteristic of scarlet fever. The more or less desquamation of the tongue, leaving it bright red and rough, with prominent papillæ, does not occur in any other disease, and is therefore characteristic. If the term "strawberry" is to be applied at all, it should be to the rough, bright-red tongue with prominent papillæ.

Complications.—The chief sequel, the only one which is at all common, says Rotch,[2] is nephritis; but cardiac disease, commonly secondary to the nephritis, may occur. Lesions of the other organs are unusual, and have no direct connection with the scarlet fever; they are due partly to the fever and partly to the septic processes which have arisen in the course of the disease, and are represented, as would naturally be expected, by a congested condition of the various internal organs, and by the usual changes which are found in pleuritis, pericarditis, endocarditis, and meningitis. Scarlet fever may begin with such great cerebral excitement as to lead the physician to suspect meningitis, and it may not be possible to make a diagnosis until the efflorescence has appeared, which may not be until the eighth or ninth day. Most of the complications which arise in scarlet fever are due, probably, to the action of streptococci, either isolated or associated with other micro-organisms. These micro-organisms produce serious symptoms, which are often followed by death, either directly, giving rise to septicæmic processes, or indirectly, by nephritis. The earlier in the course of the disease the symptoms of nephritis appear, the severer, as a rule, will be its type. The extent of the albuminuria is of less consequence than the total quantity of the urine. A rapid and extensive diminution of the urine is ominous, as it indicates the accumulation of nitrogenous waste in the blood and the danger of a resulting uræmia. The albumin occurring early in the disease is more apt

[1] N. Y. Med. Jour., May 22, '97; Univ. Med. Mag., May, '97.
[2] Boston Med. and Surg. Jour., May 27, '97.

to be in large quantities than when it appears first in the third or fourth week. Hæmaturia is frequently present in this form of nephritis, but ordinarily of itself adds little to the gravity of the disease. The œdema of the face may be followed by a rapid involvement of the ankles and legs, and at times it may become general. During the course of a general œdema the desquamation is apt to cease and to return on its disappearance. The œdema may last for months or may pass away quickly; it may be entirely absent, but in such cases the nephritis is almost invariably of a light grade. At times, during the presence of a general œdema serous effusions into the pleura may occur. Œdema of the lungs and brain, though very rare, may also supervene. Instead of a slow development beginning with œdema of the face, there may be an acute attack, ushered in by fever, vomiting, headache, œdema, amblyopia, coma, and convulsions. Relapses may occur many weeks after an attack of scarlatinal nephritis, and the case should be watched with the greatest care for several months. The nephritis of scarlet fever, although it may last for several months, has a tendency to ultimate recovery in children, on account of their wonderful recuperative powers. It is also rare for the renal disease following scarlet fever to become chronic. Retinitis and amaurosis at times occur during the progress of the nephritis. Rotch states that in the cases of amaurosis it has been noticed that, although the loss of sight may be complete, almost always where uræmia and amaurosis are coincident there is found no perceptible change in the retina, no congestion of the papillæ, no increase of the intracranial pressure, and no intense œdema of the brain. The sight, under these circumstances, may be recovered completely.

Regarding scarlatinal albuminuria, Dittmar[1] observed the urine of ninety-one consecutive cases of scarlet fever varying in age from one year and two months to fifty years, the majority, 84.6 per cent., being under fifteen years, and 62.6 per cent. being under ten years of age. In some cases as many as three or four specimens from each patient were analyzed daily, and, in all, over ten thousand specimens were examined for albumin and hæmoglobin. One or both were detected at some period in 52.7 per cent. of cases, and of these 60.4 per cent. were under ten and 81.2 per cent. under fifteen years of age. In most of the cases the quantity of albumin was small, and could be detected only by careful testing; in some cases merely an occasional trace was detected, but in others it persisted for weeks and was sometimes very considerable. In some of the cases "blood" alone seemed to be present, the albumin bearing a proportion to the hæmoglobin such as exists in normal blood. In other cases both blood and albumin were found, the amount of the latter being out of all proportion to the hæmoglobin. There was no particular date on which albumin seemed particularly prone to appear, although a relatively large number of the cases showed the presence of an abnormal constituent during the latter half of the first week, during the second week (ninth to the twelfth days), and on the thirty-first day than at any other period of the illness. The cases seemed to divide themselves into cases of "early" albuminuria, and cases of "late" albuminuria. Twelve cases were "early" albuminuria, and in nine of these the albumin disappeared

[1] Glasgow Med. Jour., Dec., '97.

only to reappear again later in the disease. The interval during which the urine was free was from three to forty-eight days.

The somewhat rare occurrence of various paralyses in the course of scarlet fever has been studied by Alexieff,[1] who has only been able to collect 7 or 8 published cases, together with 2 coming under his own observation. The first suffered from left hemiplegia about three weeks after the eruption, the face, tongue, and upper and lower limbs being affected. In about twelve days a marked improvement set in, progressing to complete recovery. In the other case there was complete paralysis of the right half of the body; the paralysis was of a particularly marked degree, with loss of the right naso-labial fold, complete loss of power in both upper and lower limbs and the right side, loss of knee-jerk, and impaired sensation. There were no symptoms of endocarditis, but bronchopneumonia with a marked degree of albuminuria. On post-mortem there was subacute parenchymatous nephritis, degeneration of the cardiac muscle, thrombosis of the left middle cerebral artery, and almost complete softening of the lenticular nucleus and of the posterior portion of the internal capsule.

Symes[2] remarks that rashes during convalescence are by no means of uncommon occurrence, and they should not be confounded with the true relapse, in which the patient passes again through all the stages of the first attack. The true secondary rashes are of importance, however, as they frequently indicate the beginning of a period fraught with grave danger.

Secondary rashes may be erythematous, urticarial, eczematous, papular, or hæmorrhagic, and generally appear in or about the third week, and almost invariably in patients in whom the initial throat symptoms have been of more than average severity. Although the appearance of the skin lesions frequently coincides with a recrudescence of amygdalitis, Symes does not think it likely that they are the result of septic absorption from fauces. In some cases no amygdalitis is observed; and there is seldom any ulceration or sloughing; in others the rash precedes the appearance of tonsillar trouble. Probably about the third week there is a certain period, during which certain products of the disease are being eliminated, when the organs engaged are apt to suffer. In the digestive system such disturbance is marked by diarrhœa and vomiting, and in the kidneys by nephritis and albuminuria, the latter of so slight a nature, perhaps, as to be disregarded. The lymphoid tissue of the tonsils and the lymphatic glands are noticeably excitable, and that great excretory organ, the skin, is frequently affected. The septic rashes are accompanied by much wasting, and the mortality is very high. Symes cites Mahomed, who observed that in scarlet fever there are certain changes of constant occurrence between the eighteenth and twenty-second days of the illness, such as a rise of temperature and arterial tension, along with diminished excretion of urine and urea, albuminuria, bronchorrhœa, adenitis, and diarrhœa. Secondary rashes appear to have received but little attention.

Seitz[3] remarks that recidives of the rash are often noted, usually after eight to ten days. Nephritis is not affected by season, nor by diet, but is dependent on the character of the reigning epidemic. In patients under practically

[1] Jour. de. Méd., July 10, '97.
[2] Bristol Medico-Chir. Jour., March, '98.
[3] Munch. med. Woch., No. 3, '98.

uniform conditions, the frequency of nephritis varies from 9 to 41 per cent. in different seasons. The greatest proportion happens in summer and the complications — sometimes hæmorrhagic, sometimes uræmic—occur even in children on milk diet and in bed. Many cases of so-called intermittent albuminuria and chronic nephritis are due to unrecognized or neglected scarlatinal nephritis.

Littlewood[1] reports case of gangrene in a boy aged 4 years. Numerous small discolorations were noticed extending over both lower limbs from the toes to within two or three inches of the knees anteriorly and posteriorly. The scarlet-fever process followed a favorable course, except that day by day the discolorations of the limbs became more marked, though continuing patchy, lividity being most intense at the toes and feet, and becoming less so from below upward. On the twelfth day the limbs retained a considerable degree of warmth, probably somewhat exaggerated by the more or less continuous application of artificial heat, but in neither limb could pulsation in the femoral arteries be distinctly felt.

Pain now appeared, apparently of an intermittent character, and the discoloration spread to some four inches above the knee anteriorly and to slightly above the centre of the popliteal space posteriorly, being almost exactly similar in both limbs. During the next five days the temperature subsided to the normal. Five days later an oblique line of demarkation formed, roughly extending in both limbs to three inches above the knees in front and to the centre of the popliteal spaces behind. At this time cardiac dilatation was noted, together with a suspicion of roughness of the first sound at the apex. Amputation was accordingly advised and carried out.

Goodall[2] reports case of a girl, 8 years of age, who, on the eleventh day of scarlatina, had convulsions, followed in a few hours by general rigidity and coma. The temperature reached 107° before death. No albumin could be detected in the urine. The autopsy showed thrombus in the veins of Galen and the right lateral sinus. The choroid plexuses were covered with a thick coating of fresh lymph. The optic tracts showed red softening. The ears were normal, but slight ulceration of the tonsils present.

Recurrence.—Drake[3] reports a case in which the patient had two distinct attacks of scarlatina, exfoliation of the epidermis occurring after each attack.

Millard[4] remarks that the true malignant form is now fortunately comparatively rare, and in consequence scarlet fever is no longer the dreaded and fatal disease it was formerly. What this change in type is due to we do not know, but it is to it rather than to any improvement in methods of treatment that we must chiefly attribute the remarkably-low case-mortality which now obtains. When the true malignant form does occur, we are forced to realize how helpless we still are. Out of an experience of over 5000 cases Millard can only remember seeing three undoubted cases in children under four months of age.

Treatment.—Huber and Blumenthal[5] experimented with the blood of persons convalescent from scarlatina. Blood was drawn from a vein of the elbow; the serum was mixed with an equal amount

[1] Lancet, Lond., July 10, '97.
[2] Proc. Royal Soc. Med. and Surg., Mar. 23, '97.
[3] Med. Rev.; Amer. Prac. and News, May 15, '97.
[4] Brit. Med. Jour., Jan. 15, '97.
[5] Berlin. klin. Woch., No. 36, '97; Gaz. Heb. de Méd. et de Chir., Nov. 21, '97.

of physiological solution of salt, 1 per cent. of chloroform added, and the mixture passed twice through a Beckfeld filter. The serum was used in thirteen cases of scarlet fever. It mitigated and shortened them all.

Gordon[1] records the case of a boy, aged 6 years, in an apparently-moribund condition on the fourth day of an attack of scarlatina, but who revived under stimulant treatment, and seemed to improve until the seventh day, when he grew rapidly worse and seemed to be dying from septicæmia; was semicomatose, with failing heart, dusky rash, and diarrhœa; pulse, 180; temperature, 103°; offensive discharge from fauces containing streptococci and staphylococci, but no bacilli. Ten cubic centimetres of streptococcic serum were injected under the skin of the abdomen. The next day the temperature was 103°; the pulse, 106 and stronger; the fauces less offensive, and the heart less dilated.

Another dose of 10 cubic centimetres was then given. After this no bad symptoms were observed, and the boy made a good recovery, convalescence occurring very much sooner than is usually the case with those who have had septic symptoms. Gordon suggests that this treatment may be valuable in septic cases when the signs exist from the first and are not in proportion to the severity of the throat symptoms, or when the condition is due to the absorption from a sloughing throat or nose. Later[2] he states that the serum is not of much value in cases where the septic symptoms appear late and are due to absorption from sloughing tissues, but strikingly good result may be obtained when there is septicæmia at the onset and the serum is given early.

M. Roger[3] says that, out of a hundred and eighty-three cases during six months, only two died. He determined to make trial of the serum treatment. At eleven o'clock in the morning phlebotomy was practiced, and afterward eighty cubic centimetres of defibrinated blood taken from a patient convalescent from scarlatina were injected under abdomen. Five hours later the patient was sleeping quietly and breathing easily. When he awoke and moved, the respiration changed and became the Cheyne-Stokes type; the pulse was 120 and feeble; the tongue moist; the temperature, however, remained high and no urine was passed. A bath at 82° F. was then given and the temperature began to fall. Three hours later twelve ounces and a half of saline solution were injected subcutaneously, and in an hour urine was passed. Two hours later the patient was sleeping quietly; the pulse, 100; and the respiration 25. On the following day the patient felt better and asked for food; his tongue was raw, but moist; the eruption was pale, except on the legs, where it was still very pronounced; pulse feeble, but regular, with 80 pulsations; respiration, 22. During the twelve hours following the last injection the patient passed eleven hundred cubic centimetres of urine, of a dark-red color, but it contained no albumin. The temperature during the day ranged about 100.2° F., and on the following day became normal. M. Roger says that he has never seen such rapid recovery follow in such a grave case.

Rappapart[4] declares that antistreptococcic serum, even when injected repeatedly, has no influence either on the temperature or on the complications; four of the patients died.

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[1] Lancet, Lond., Jan. 2, '97.
[2] Proc. Laryngol. Soc., Lond., March 10, '97.
[3] Presse Médicale. Aug. 26.
[4] Bolnit. Gaz. Botk, No. 40, '97.

Seitz[1] insists that the angina of scarlet fever is rarely diphtheritic. Out of 800 cases 200 had pharyngeal false membranes, but paralysis followed in only 1 case. Of 98 in which cultures were made, Loeffler's bacillus was numerous in 3 and scanty in 4, in repeated cultures; he, therefore, rejects antitoxin in scarlatinous angina and uses Heubner's injections of 3-per-cent. carbolic acid, in the tonsil and soft palate, with cleansing and antiseptic applications by gargle, spray, and swab.

Only those diuretics should be used which do not irritate the kidney, declares Rotch.[2] Acetate of potassium is one of the safer agents of this class in this complication. In severe cases, with general œdema and threatening uræmia, cathartics are rather more certain in action than diaphoretics and diuretics, and are specially indicated where, as is usually the case, constipation is present. Podophyllin, in loses of $^1/_{10}$ grain, may be given to a child 5 years old, and be repeated a number of times; it usually acts quickly. The compound jalap powder, in doses of from 5 to 10 grains, may also be given where a rapid and decided derivation by the intestine is indicated. If the skin is hot and dry and uræmic symptoms (usually represented by anuria, somnolence, amblyopia, and headache) are present, resort may be had to the hot pack either wet or dry. In these cases it is preferable to have the child wrapped in a blanket and placed directly in a tub containing water at a temperature of from 105° to 107° F.; it should be kept in the water fifteen or twenty minutes, or even longer if necessary, then be taken from the wet blanket, enveloped in hot, dry blankets, and kept in them until the skin has become moist and reaction has taken place. While the child is in the bath, milk may be given, and stimulants if they are indicated by a weak and intermittent pulse.

Hydrochloride of pilocarpine in doses of $^1/_{20}$ to 1 grain may be given by the mouth to a child of 2 years, and subcutaneously if desired to a child 5 years of age. In these cases of threatened uræmia convulsions sometimes appear quite suddenly. Under these circumstances enemata of hydrate of chloral, from 5 to 10 grains dissolved in water, are of value in controlling the nervous phenomena; but Rotch prefers a combination of bromide of potassium and hydrate of chloral. Where the ascites is extreme, paracentesis abdominis is often of great value, not only in relieving the pressure, but also in increasing the action of the diuretic, which, perhaps, before was not acting freely. Digitalis is a valuable remedy, especially adapted to the treatment of the nephritis of scarlet fever and to that of the cardiac changes which result from it. By the administration of this drug the flow of urine is increased; but is best given in the form of a freshly-prepared infusion, in teaspoonful doses every four hours, to a child 5 years old. Nitroglycerin is valuable where the action of the heart suddenly becomes feeble and irregular.

Pujador[3] also advises hypodermic administration of turpentine, with bicarbonate of soda added to it to prevent local irritation at the point of injection, in doses of 1 gramme daily for a child of from 3 to 6 years or 3 grammes, at the utmost, to an adult. If not well borne it may be given in capsules or emulsion. It prevents the occurrence of nephritis, or arrests it if it has already appeared.

Wiglesworth[4] gives carbolic acid as

[1] Munch. med. Woch., No. 3, '98.
[2] Boston Med. and Surg. Jour., May 27, '97.
[3] La Méd. Infant., Sept., '97.
[4] Lancet, Lond., Oct., '97.

soon as the disease is suspected—laying great stress on the fact that the treatment must be begun early—in doses of from 1 to 6 grains according to age, freely diluted with water, and repeated every two hours as long as the rash remains visible. He then reduces the dose and the frequency of administration till convalescence is established. He claims to have pursued this practice for sixteen years with almost uniformly good results. He also gives the drug in the same doses as a prophylactic to other children, and, as soon as the color of the patient's urine shows that he is "carbolized," he allows other children to associate freely with him, with the certainty they will not take the fever at all or will take it very mildly.

Alfaro[1] prevents nephritis in scarlet fever by promoting free diuresis, adherence to strict milk diet, plenty of drinks, and cold hydrotherapy in severe cases. And further he strives to avoid the elimination by the kidneys of any irritating substances either from medication or from the food (inhibits phenol-salicylic acid, antipyrine, acetanilid, etc.) by keeping the functions of the skin as active as possible by general friction with fatty substances and tepid bath during desquamation; by keeping the mouth, nose, and pharynx aseptic with frequent mild antiseptic applications to prevent the introduction of the streptococcus into the general circulation; by avoiding sudden or continued exposure to cold air. Lastly, he insists that no antipyretics or antiseptics shall be employed that can possibly affect the kidneys injuriously by elimination or absorption.

Scarlatinal Nephritis.—Kontrebinsky[2] says that the generally admitted pathogenesis of post-scarlatinal nephritis is autoinfection from the scarlatinal virus whose toxic products can no longer be eliminated by the diseased kidneys. The chief aim should be to prevent the retention of these products by the organism, in two ways: (1) by combating the nephritis itself; (2) by heightening the excretory function of the skin and the intestines, or supplementing them by suitable means. To fulfill the first indication—*i.e.*, to lessen the formation and spread of the toxins—the most efficacious means are: more or less absolute milk diet, according to the gravity of the case, combined with hydrocarbons; proscribing absolutely meat and eggs; rest in bed for three weeks at least; alkaline waters, Vichy particularly; pure air, constantly changed. The second indication is met by giving diaphoretics and purgatives and using other means to heighten the activity of skin and bowels for the elimination of the toxins, thus relieving the kidneys. As soon as albuminuria disappears, cutaneous perspiration also increases; to aid in this increase have recourse to warm baths and hot compresses—the air of the room should be uniformly warm: 95° F.—for fifteen to twenty minutes at a time; purgatives, enemata of warm water, and infusion of senna. Calomel is to be avoided.

TONSILLITIS, ACUTE.

Etiology.—Taylor[3] thinks febrile and other remote symptoms of this disease are due to a primary lesion.

Treatment.—Cleanse the tonsils, as far as possible, by a swab; then direct into each crypt a blast of air through a fine tube to blow out organisms, etc. Next spray the crypts with 1 to 3000 sublimate solution; finally paint the

[1] Anels del. Circ. med. Argentino, Oct. 15, '97.
[2] Jour. de Clin. et de Thérap. Inf., No. 1, '97.
[3] Jour. Amer. Med. Assoc., No. 6, '97.

tonsil with nitrate of silver, 40 grains to the ounce of water. Iodine is not to be recommended in acute stages.

Kramer[1] employs parenchymatous injections of carbolic acid in severe tonsillitis, particularly where it is thought that there is a tendency to abscess-formation. The part is made completely anæsthetic by cocaine, a sterilized needle attached to a Pravaz syringe gently introduced into the gland, and through this is injected from 7 to 15 minims of a 2- to 3-per cent. solution of carbolic acid. This may be repeated once or twice a day.

UTERUS, RUPTURE OF.

Donald[2] was called to a non-gravid woman who had been treated for uterine hæmorrhage. She was in extreme collapse, very blanched, with a pulse of 150 as far as it could be counted; respirations shallow and sighing. On vaginal examination the finger passed into the uterus and then through an aperture in its posterior wall into the abdominal cavity and into the tissues of the left broad ligament. Under anæsthesia the parts were carefully disinfected, and an opening made with a snip of the scissors through the posterior vaginal fornix into the pouch of Douglas, which allowed the escape of a large quantity of fluid and clotted blood that had collected, and permitted the nature and extent of the tear to be made out from the peritoneal aspect. The uterus was then rapidly excised by Doyen's method, being first split up into two halves, each half dragged down to the vulva and pressure-forceps placed on each broad ligament from above downward. The points of the forceps were then turned up into the pelvis, and the gap in the vaginal vault packed with iodoform gauze. Hysterectomy was selected in place of suturing the tear or plugging with gauze, because of the rapidity with which it could be carried out and of the security against further bleeding. The advantage of pressure-forceps over ligature in cases in which rapidity is essential must be obvious. Donald thinks that this method might be adopted with advantage in some cases of rupture of the uterus during labor. The great advantage of the vaginal, as compared with the abdominal, incision lies in the almost complete absence of shock.

Metcalf[3] refers to a case of spontaneous rupture of the non-pregnant uterus, the "only one recorded" (he thinks), due to tubercular degeneration. Some writers declare that it may be caused by carcinoma, and some early writers report instances of rupture during early pregnancy, always in a horn of the uterus, but all such, Metcalf thinks, are open to suspicion as cases of extra-uterine pregnancy.

VOMITING, INTRACTABLE.

The uncontrollable vomiting after abdominal section is believed by Thompson[4] to be, almost invariably, an evidence of interference in the circulation of some vital organ. Its presence is far more ominous than that of an abnormal pulse, an embarrassed respiration, or a rising temperature; and, when it has persisted more than twenty-four hours without abatement, he believes reopening of the abdominal cavity should be seriously considered, with the view of relieving some internal strangulation or tension.

Greene[5] speaks highly of the good effects of hourly hypodermic injections of $^1/_{40}$ grain of morphine in otherwise-

[1] Schmidt's Jahrb., Jan., '97.
[2] Lancet, Lond., Mar. 5, '97.
[3] Atlan. Med. Week., Dec. 25, '97.
[4] Medical Age, April 25, '97.
[5] Brit. Med. Jour., vol. ii, '97.

intractable vomiting. If this and all other possible measures fail, and life is seriously endangered, he suggests intubation of the larynx with a special modification of O'Dwyer's tube. If this be unsuccessful, tracheotomy is the last resort. The idea is that vomiting is impossible if the glottis be kept open.

Editorial.

THE amount of current and review literature at our disposal is so great that the space usually employed for editorials will henceforth be utilized for the accommodation of the excess of matter whenever it is deemed necessary for the best interests of our readers. Editorials will be reserved for the consideration of especially important questions relating to any of the subdivisions of progressive medicine and surgery.

Cyclopædia of Current Literature.

ABDOMEN, RARE PENETRATING WOUND OF.

A rare injury occurred to a Burmese male aged 30 years. While squatting Eastern fashion in a corner of the house with his back to the wall, some one outside stabbed him in the buttock through the thin bamboo matting that formed the side of the dwelling, making a transverse wound $1\,^1/_2$ inches long at the level of the lower end of sacrum and just to the right of the middle line. A probe passed about one inch and impinged upon bone. Examination of rectum revealed no injury. Pulse good; no evidence of shock; little pain. Eleven hours later he was moribund, his abdomen distended, and signs of much fluid within it. He died shortly afterward.

On autopsy the track of the wound was found to pass between the sacrum and the coccyx. The floor of the pelvis to the right of the rectum was perforated, and a coil of small intestine about midway between the stomach and great intestine, hanging in the recto-vesical pouch, was wounded. The abdomen contained a great quantity of blood, the source of which was not demonstrated, but probably came from the right iliac vein or one of its large tributaries. Duer (Lancet, Lond., Mar. 5, '98).

AMBLYOPIA, RARE.

Though various kinds of toxic amblyopias are recognized, yet, with the exception of those due to tobacco and alcohol, the affection is rarely met with. A man, aged 46, found his eyesight failing for more than a year; he was strong, healthy, and had seemingly always led a very regular, methodical, temperate life. He smoked a pipe of strong tobacco after each meal, and drank one glass of beer at dinner. Beer and tobacco were stopped, but he did not improve. Finally the fact was elicited that for years he had consumed daily twelve cupfuls of strong cheap tea. The latter habit was suspended, the beer and tobacco

resumed, and from that moment vision gradually and steadily improved. Campbell (Lancet, Lond., Mar. 12, '98).

BERIBERI.

Pathology.—Three kinds of bacilli were found in tissues carefully secured from cases of beriberi in Senegal. One is a large bacillus six to ten microns in length and three-tenths to four-tenths micron in width, which is found especially in the kidneys; second, a medium-sized bacillus, three to four microns long and three-tenths micron wide, seen especially in certain vessels, as those of the kidney; the third is a very small bacillus, occurring in enormous numbers in the blood. The first two are probably of the same nature; as to the third, it is probably derived from the others. Nepveu (La Sem. Méd., Feb. 2, '98).

BLEPHARITIS.

Treatment.—Picric acid is extremely useful in blepharitis. During three months it was employed with very good results in different cases, and in some in which other treatment had shown no tendency to cure. It is, perhaps, best employed in solutions of 5 or 10 in 1000 parts; also with glycerin to render the preparation more adherent to the ciliary borders. The yellow staining of the skin by the acid is no drawback, since it soon passes away. Fage (L'Echo Méd. du Nord., Jan., '98).

CHELIDONINE.

This akaloid, obtained from *chelidonium majus* has been offered as a substitute for morphine to relieve pain. Report of six patients suffering from carcinoma of the stomach, one each from tabes dorsalis, osteomalacia, and arthritis fungosa, who received varying doses of the sulphate—from 1 to 6 grains daily—without any result. Guth (Therap. Monatshefte, H. 10, '97).

COCAINE POISONING.

Symptoms.—A robust man, aged 40, took, by mistake, two hours after dinner, 10 grains of cocaine muriate along with an equal quantity of ammonium bromide. Within five minutes he expressed himself as feeling wonderfully well; half an hour later he felt "very funny," and complained that hands and feet were numb and that he seemed to be walking on cotton-wool. This was followed by spasmodic jerkings of the limbs preceded by a sense of restraint. His jaw troubled him by "rattling" and his mouth appeared dry,—in reality it was anæsthetized. The eyeballs were notably protuberant and perfectly immobile, evidently from paralysis of the motor oculi muscles.

The levatores palpebrarum were unaffected; pupils fixed in the state of semidilation; facial expression very haggard. While in this state 3 drachms of wine of ipecac were given with warm water, which caused emesis. About forty minutes after the poison was ingested, speech became quick and hurried; the breathing very oppressed—the oppression being principally on expiration—and gradually increased until the rate sank to about 8 per minute; but there was no cyanosis, possibly from the fact that the pulse had increased in rapidity to 120 per minute and was full and bounding.

Treatment.—As the breathing became worse, $^1/_{10}$ grain of strychnine and $^1/_{100}$ grain of digitaline were given hypodermically. The effect was immediate: the respiration was relieved, though the pulse-rate remained as before; and from this time the danger seemed less immi-

nent. The breathing, at times, became labored, but never again to the extent it had reached prior to the administration of the antidote. The subsequent history of the case was one of gradual improvement, aided, doubtless, by cupfuls of strong, hot coffee, which was comforting and seemed to stimulate the respiratory apparatus. About two hours after ingestion of the cocaine the patient again commenced to vomit and passed large quantities of urine, but whether from the poison or from the treatment could not be determined. Urination was performed without difficulty, but there seemed to be an inappreciation of relief natural to the removal of the tension of a full bladder. Perspiration throughout was very free. The knee-jerks were not absent, but appeared defective. The total duration of the symptoms was about seven or eight hours. The next day the patient, though languid, was able to resume his occupation.

It would seem, from this case, that cocaine is, in a measure, selective: first, the nerves of the motor oculi muscles were affected; secondly the vagus; and lastly the nerves to the mucous surfaces and the skin.

Is it not possible that instillation of cocaine into the eye may be of value in those troublesome cases of idiopathic nystagmus that are met in general practice? Palmer (Lancet, Lond., March 12, '98).

CRUSTA LACTEA.

Treatment. — Benzoated zinc-oxide ointment is an excellent application to relieve the local distress that accrues to infantile eczema. Fowler's solution of arsenic should be given internally, along with ammoniated iron citrate; attention should also be paid to the connection of indigestion and malassimilation and to the restoration of strength. Kistler (N. Y. Med. Record, Feb. 12, '98).

CORNEAL ULCERS.

Treatment.—Great benefit is promptly obtained from the following:—

℞ Santonin, $^1/_4$ grain.
Calomel, 1 grain.
Sugar of milk, q. s.

giving one every hour, following the last fourth with a dose of castor-oil.

After full operation of the remedy and restriction of diet to nourishing food, the disease rapidly disappears. Hansell (Phila. Polyclin., March 26, '98).

CORYZA OF CHILDREN.

Treatment.—One drop of a 2-per-cent. solution of cocaine (in equal parts of distilled water and glycerin), instilled into each nostril three or four times daily with a medicine-dropper, causes immediate opening of the nasal passages; so that the child can readily breathe through the nose and rhinoscopy can be carried out. This method is not dangerous, and the effect can be readily estimated by watching pupillary dilatations. It may be employed even for nurslings. Naegeli-Akerblom (Ther. Woch., No. 57, '97).

ECZEMA.

Treatment.—Carefully cleanse the affected surfaces by constant application, for a longer or shorter period of time, of cold potato poultices, often renewed, and cover with elastic tissue, no antiseptic being added. When the surface has been thoroughly cleansed, scarify with a sharp point in parallel lines, one to two millimetres apart, down to the superficial layer of the derma. Allow blood to flow freely, and ever promote

the hæmorrhage by application of tepid, boiled water; the surface is then to be dressed with a few folds of tarletan steeped in boiled water until potato poultices can again be applied. These latter are kept in place three or four days, when every trace of scarification has disappeared. Carried out in this manner the scarifications are well borne, even by children. The invariable result is that a few minutes after the operation there is increase of redness, with slight tension and heat; these phenomena last one, or, at most, two days, after which redness, swelling, heat, smarting, and itching are distinctly less than before. By this method, eleven cases of eczema of different kinds, all of which had proved refractory to other recognized modes of treatment, were cured. Among these were 3 cases of lichenoid eczema (of the dorsum of the feet, of the hands, and of the forearm); 1 old bilateral eczema of the pre-auricular region; 3 of the face in adults, and 4 in the face of children. Six to seven scarifications, according to the nature of the case, are required, and, as a general rule, the resistance to the treatment increases in a regular ascent from acute eczematization to lichenoid eczema. Jacquet (La Sem. Méd., Mar. 2, '98).

A small piece of buckskin placed between the ointment and the remainder of the dressing is recommended. It is flexible, which permits of its accurate molding to the diseased area, and it does not absorb much of the ointment, and thus keeps the parts moist. Finally it does not adhere to the newly-formed cutis, as linen does, or produce cutaneous irritation like rubber. Darezac (Jour. de Méd. de Bordeaux; N. Y. Med. Jour., Feb. 12, '98).

A case was cured by two months' use of the following:—

℞ Oil of cade, 5 parts.
Zinc oxide, 10 parts.
Green soap, 10 parts.
Vaselin, 10 parts.

Also a mercurial plaster was applied at night. Block (Deut. med.-Zeit., Jan. 3, '98).

EMETICS.

This class of drugs is too much neglected. Emetics, besides clearing the bronchi, increase oxidation. The gaseous changes in respiration are increased in every detail, this action being partly mechanical (a larger quantity of air passing in and out) and partly vital (there being a greater amount of oxygen absorbed and more carbonic-acid gas given out per volume of expired air). Emetics are of the same value in infective bronchitis as purgatives in intestinal affections, while there are few contra-indications. Robin (Bull. de l'Acad. de Méd., No. 4, '98).

ENURESIS.

Treatment.—Persistent nocturnal incontinence in women may be treated by distending the bladder at a low pressure with boric-acid solution and then passing a constant current through the bladder by placing the negative pole in the irrigating fluid and the positive over the lumbar spine. One case cured after some twenty years' persistence, and the capacity of the bladder raised from 4 to 20 ounces. Nason (Brit. Med. Jour., Feb. 8, '98).

EUSTACHIAN INFLAMMATION.

Etiology.—Natural gas is a potent factor in causing catarrhal inflammation of the whole pneumatic system, with special reference to the Eustachian tube.

Symptoms and Diagnosis.—The symptoms referable to the ear are not typical

of acute catarrhal inflammation, but are rather of a subacute form; the disease may, however, assume a chronic form. The deafness that arises may be differentiated from catarrhal deafness *per se* by the ease with which the patency of the tube and mobility of the drum are restored.

The throat symptoms in the chronic form resemble those of clergyman's sore throat.

Treatment.—In the acute stage this is palliative and sedative; but little success will result unless lights from jets are condemned and oil or electricity substituted. Politzer's method should be employed, condemning the cannula; also hot application and massage, which relieve congestion and promote absorption of any serous exudate within the middle ear. Frequently a change of surroundings is absolutely necessary. In the chronic stage absolute reliance is placed on the galvano-cautery. The stenosis of the tube calls for inflation through the Eustachian catheter, with soothing injections and massage of the drum. The septal hæmorrhage that occurs in this form, owing to the formation of crusts and the habit of picking the nose, may be relieved by destruction of the superficial blood-vessels by means of the actual cautery or a strong solution of silver nitrate. The crusts are softened and healing stimulated by yellow-oxide-of-mercury ointment, or ichthyol, 3 per cent., in lanolin. Kyle (Jour. Amer. Med. Assoc., March 19, '98).

EXOPHTHALMIC GOITRE.

Pathology.—The enlargement of the thyroid gland may be regarded as compensatory, for the changes are identical with those produced in the remaining part of the thyroid in animals after the removal of a part of the gland. Researches seem to show that the thyroid has no secretory nerve corresponding to the chorda tympani, and that any nervous influence that may exist is not central, but due to ganglia either in or in the immediate neighborhood of the gland; and, further, that, at least, the enlarged thyroid is not primarily of central nervous origin. Regarding the functions of the parathyroids in dogs, it seems as if they had as much—or more—to do with saving the animals from acute myxœdema as the thyroid proper. Experiments on monkeys showed that the extract of sheep's thyroids might keep off and relieve the symptoms following thyroidectomy, but could, as a rule, not save their lives. Edmunds (Jour. Path. and Bac., Jan., '98).

Symptoms.—In two cases both lobes of the thyroid were invaded with marked tachycardia; pulse, 100 to 130; leukæmia; some œdema of ankle and eyelids; no albuminuria nor heart-valve disturbance, but headache and great restlessness.

Treatment. — The positive electrode moistened with a saturated solution of potassium iodide was applied to the gland and the cathode to the nape of the neck, for five to ten minutes every other day for six weeks, using a current of four milliampères. At the end of this time the gland was reduced to its normal size; pulse, 78 to 80; restless sleep; increased body-weight; disappearance of headache. Page (Jour. Electro-therap., Feb., '98).

Jonnesco, Faure, and Abadie (Le Progrès Med., Oct. 23, '97) all advocate section of the cervical sympathetic as the surest and safest; Abadie thinks that simple section is all sufficient, but the other two advocate resection and extirpation of the ganglia.

GASTRIC ULCER.

Treatment. — Excellent results have been secured by giving large doses of bismuth,—30, 40, even 50 grains three times a day,—suspended in water, after ordinary doses had failed to be of benefit. Under these the pain was rapidly relieved, vomiting ceased, digestion improved — allowing light, nitrogenous food, such as fish or fowl, to be given —and the ulcer quickly healed. The bismuth sometimes caused a little pain and diarrhœa, but never constipation. The treatment was employed chiefly in chronic cases, but in some of the acute variety after recent hæmatemesis it also proved successful. In acid dyspepsia, too, it rapidly relieved the symptoms. There are certain dangers and inconveniences that attend the use of the stomach-tube and lavage, but in some cases such a procedure seems imperative: here it is best, after lavage, to inject from 300 to 450 grains of bismuth suspended in water through the tube. Dreschfeld (Lancet, Lond., March, 5, '98).

GENU RECURVATUM.

Etiology.—A lad, aged 17, had been treated, when 5 years old, for an abscess in the right thigh. After this had been opened, there was, during two years, a continuous discharge from two openings which, when finally closed, were replaced each by a permanent scar, one superficial and mobile, on the front of the thigh, the other depressed and fixed to bone, on the outer surface.

Pathology.—The deformity, which developed slowly after the complete healing of the abscess, was characterized by marked hyperextension of the right leg, which formed with the thigh a retiring angle of 160°. When the patient was recumbent on his back, the only portion of the right limb which touched the couch was the popliteal region. The patella was elevated far above the knee, and fixed in front of the thigh. The muscles of the thigh were much wasted. The leg was fixed, and the affected limb shorter than its fellow by a little more than two inches. A stiff and tense cord, evidently formed by the lower half of the quadriceps muscle stretched from the middle of the thigh to the patella. It was assumed that the previous suppurative affection—probably of osteomyelitic origin—had resulted in abnormal adhesion of the extensor muscles to the front of the femur, and that the portion of the quadriceps intervening between two fixed parts—namely, its insertion below and its adhesion to the bone above—had been prevented from keeping pace with the femur in the vertical growth of the limb; and had thus produced slow and continuous hyperextension.

Treatment.—It was decided to separate the adherent portion of muscle from the bone, and thus to overcome the hyperextension, and to re-establish normal relations of the articular surfaces of the knee. An operation, which consisted in subcutaneous detachment of the quadriceps from the femur, and in division of the tense cord formed by the lower part of the muscle, was followed, after a time, by satisfactory results. The limb was restored to the normal position, and almost to the length of the sound limb, and there is now a fair, though not complete, range of the movements of flexion and extension at the knee. Marchant (Rev. d'Orthopédie, No. 1, '98).

GONORRHŒAL ARTHRITIS.

Treatment. — Local applications are usually recommended, fomentations of turpentine being possibly the most typical. Quinine hypodermically and in-

ternally is the best remedy against infections, in general, and also because the results seem to indicate that it has a specific action on the gonococcus. We may reject Bouchard's "pseudorheumatism" and Gerhardt's "rheumatoid arthritis," and call these affections by the name of the inducing affection. Maragliano (Gaz. de Osp. e d. Clin., Feb. 6, '98).

HÆMATOMA OF VULVA.

A woman, aged 42, was easily delivered of her ninth child shortly after the membranes had ruptured. The placenta came away spontaneously. She went to sleep, and awoke with a feeling of tenseness in the perineum. Three hours later was discovered an hæmatoma as large as a fœtal head in the left labium and behind the vagina on the left. Three weeks later it burst through the inner side of the left labium; then it was emptied and the tampon applied. Two weeks subsequently to this operation the patient was quite well, but a painless, resistant mass could be felt for a long time toward the left side of the pelvic wall. There were no varicose veins in the neighborhood of the genitals during pregnancy and labor, and no history of hæmorrhagic diathesis. Wettergren (Hygeia, Stockholm, vol. lviii, Part 2, '98).

HYDROCELE.

Treatment.—The old method of injection of iodine causes a very painful inflammatory reaction, and, in common with the more recent treatment by incision and drainage, necessitates prolonged rest in bed and does not insure freedom from relapse. Instead, make a free incision into the sac, apply a 3-per-cent. solution of carbolic acid to the surface of the exposed testicle and the whole of the inner surface of the tunica vaginalis, and stuff the cavity with strips of iodoform gauze. After removal of the gauze on the third or fourth day, the wound in the skin is closed by catgut sutures. Of 18 cases treated by this method, the patients having been seen after intervals between eight months and five years from the date of operation, in 1 only was a relapse noted—this was a case of very large hydrocele in a man aged 64 years. Block (Rev. de Chir., Feb. 2, '98).

Hydrocele of the tunica vaginalis is best treated by puncture and injection of a 1 to 1000 solution of sublimate. The injection only causes a little pain in the thighs, and the fluid disappears in about a fortnight. Two injections of sublimate, without alcohol, should follow the puncture, and, lastly, a boric-acid solution injected. Twenty-seven cases thus managed were all successful. Etienne (Gaz. des Hôp., Jan. 8, '98).

The advantages of the open method —*i.e.*, incision, suturing of the vaginal tunic to the skin, and continued drainage—are: the operation can be made absolutely painless by the use of weak cocaine solutions and can be performed in the office; there is no inflammatory reaction; patients are not confined to bed and are not even prevented from attending to their usual business callings; the testicle is less likely to be injured than is the case when inflammatory reaction is set up by injections of iodine or other irritating agents; and the cure is more likely to be radical. The dressing is extremely simple, consisting of a thick mass of sterile gauze held in place by a suspensory bandage. Martin (Phila. Polyclinic, March 26, '98).

HYSTEROTOMY, SPHINCTERIC.

Division of the sphincter is more effectual than amputation of the cervix in causing involution of the uterus, and, consequently, of ameliorating certain forms of metritis and of uterine deviation. Sphincteric hysterotomy is indicated in cases in which it is necessary to insure evacuation of the contents of the uterine cavity; to facilitate involution of the uterus; and to prevent the upward extension of any infective process toward the oviducts. It is regarded as a measure of radical treatment in cases of metritis and of affections of the uterus complicated by septic inflammation, particularly uterine flexions and dysmenorrhœa of uterine origin, and also advanced retraction of the cervix. It acts by allowing complete evacuation of the uterine cavity, and by facilitating involution of the diseased organ. The operation, which is quite a harmless one, has had good results after the failure of dilatation and curetting. It should be practiced only in cases in which the expectation of conception no longer exists, or when the gravity of the affection leads to a disregard of inconvenient consequences in this respect. An autoplastic operation may in certain cases reestablish the uterine sphincter, and favor the possibility of pregnancy. Defontaine (Archiv Prov. de Chir., No. 2, '98).

ILEUS, COMBINED.

Pathology.—In four cases the occlusion was caused by several constrictions from adherences involving the small intestines complicating a cancerous stricture of the transverse colon. As the removal of one did not bring relief, the others were sought and found. In one case there was an ectopic testis; the patient recovered after the fourth operation. In all, the transverse colon was much thickened, while the rest of the walls of the large intestines were normal. In operating the obstruction in the small intestine must first be removed and colostomy established, proceeding later to the ablation of the carcinomatous tumor of the large intestine. Hochenegg (Wien. klin. Woch., Dec. 23, '97).

INTESTINAL INVAGINATION OF INFANTS.

Treatment.—Of 12 cases, 2 were cured by energetic massage, enemata, and insufflation of air. Of 7 operated on during the first two days, 2 died from shock and 5 recovered. Three were operated on after the second day, all dying from gangrene and consecutive peritonitis. From a review of 184 cases in literature it may be concluded that in operating great care must be practiced to avoid hernia later. In a case of gangrene there should be resection, enterotomy, and entero-anastomosis; but infants under a year cannot stand such a serious operation and those over a year but little better. Cordna (Gaz. de Osp. e d. Clin., Jan. 27, '98).

KIDNEY, EFFECT OF PEPTONES AND ALBUMOSES ON.

Pathology.—These substances do not exert so great an influence on the walls of the renal blood-vessels as they do on other vessels of the splanchnic area. They cause a marked increase in the secretion of urine, the maximum occurring during the second hour after injection. The urine secreted is dilute, its percentage of urea and total nitrogen being diminished. The total amount of urea and nitrogen is, nevertheless, considerably increased.

Part of the peptone (or albumose) is excreted during the first hour after injection, but the greater part appears to be retained. The amount as retained,

however, is not sufficient to supply enough nitrogen for the increased output of urea and other nitrogenous compounds. Thompson (Lancet, Lond., March 12, '98).

LARYNX, CHRONIC STENOSIS OF.

Etiology. — Chronic stenosis of the larynx may arise from a variety of causes: syphilis, wherein destruction of epiglottis and arytenoid and cricoid cartilages may cause suffocation; chronic infectious maladies, such as tuberculosis, lupus, lepra, etc.; acute infectious diseases; traumatic injuries.

Treatment. — Catheterism of the larynx, as O'Dwyer's method of intubation; dilation with bougies, either downward or upward; divulsion; operations, such as laryngo-fissure, for the later introduction of the tubes. In six cases the results of intubation were good, but only in two was a complete cure had and the tracheal tube removed. Kjeer (Hospitalstidende, '97).

LEUKÆMIA.

Pathology.—Small patches of degeneration of parenchymatous character found scattered over the surface of a spinal-cord section in two cases. There was no affection of the gray matter or of the vessels. In one case there was slight sclerotic change in the posterior columns. There were apparently no nervous symptoms corresponding to these changes. These same changes were also noted by Schultz, who found them also in chronic nephritis. Degeneration of the posterior columns of the cord has been found in anæmia and also in phthisis. Nonne (Neurol. Centralb., Feb. 15, '98).

LUPUS.

Treatment.—Especially in old tuberculous and ulcerating lupus, injections of five centigrammes of calomel every tenth day often produce remarkable cures, the improvement being evident from the first. The lymphatic infiltration and exudation processes are arrested, and then retrogress. In twenty-five cases calomel injections proved most valuable adjuvants to the usual treatment. The success in genuine non-syphilitic lupus deprives calomel injections of their hitherto assumed values as a diagnostic measure in syphilis. Asselberg (Ann. de Derm. et de Syph., Jan., '98).

MIGRAINE.

Etiology.—Many, if not most, of the cases of migraine are lithæmic in their origin. A history of irregular gout or rheumatism which is hereditary can often be had. Lithæmic migraine differs in no particular from that due to other causes. Premonitory symptoms, generally of the special senses, are common.

Symptoms.—The headache begins as a burning spot about the cheek, eye, or temple, from which it spreads until the whole side of the face and head is involved. Redness of the affected side, particularly of the upper part of the face and ear can be noticed. Nausea and vomiting are commonly present, but the attack may be strictly confined to the head. Numbness of the affected side, associated with a sensation of tingling, is noticed in most cases. The attacks may last from a few hours to several days, and may be precipitated by gross errors in diet. Narcotism following immediately upon an attack of migraine is not uncommon, although not so frequent as after bilious paroxysms.

Pathology.—The work of Rachford upon the urine of patients suffering from migraine is particularly interesting. After paroxysms of this nature he has been

able to separate two of the xanthin bases in considerable quantity from the urine, and by injecting these substances into the lower animals has induced attacks very similar to migraine in human beings. Barnes (Medical Record, March 26, '98).

NERVE-SUTURE.

Case of paralysis of the musculo-spiral nerve successfully treated by suture of the peripheral end of the injured nerve to the median. The patient was a boy, 5 years old. The severe wound associated with a fracture of the arm healed well, but a paralysis of the musculo-spiral resulted. At operation it was found that the two ends of the divided nerve were wide apart. The median nerve was therefore searched for, and a flap (base upward) of half of the thickness of the nerve was separated from the trunk and sutured at its distal extremity to the peripheral end of the musculo-spiral. The wound united by first intention, but the paralysis was not at first modified. The case was lost sight of for two years, but at the end of that time the paralysis was found to have almost entirely disappeared. Seck and Saenger (Archiv f. klin. Chir., vol. liv).

PERITONITIS, CAUSE OF DEATH IN.

In peritonitis its probable fatality arises from absorption of septic poison from the peritoneum, which poison acts chiefly on the circulation; the immediate cause of death is vasomotor paralysis. In addition to operative procedures, it might be well to attempt to obviate the vasomotor paralysis by transfusion and the administration of drugs that raise blood-pressure. Wilson (Lancet, Lond., March 12, '98).

PERTUSSIS.

Treatment. — Inject subcutaneously, every day, 35 minims of the following:—

℞ Guaiacol,
Eucalyptol, of each, 1 part.
Sterilized olive-oil, 10 parts.—M.

Chateaubourg (Centralblatt f. d. Gesammte Therapie, Feb., '98).

POTT'S DISEASE OF SPINE.

Treatment.—Immediate reduction of deformity, as recommended by Calot, is suitable only in carefully-selected cases. Generally speaking, the lower dorsal and lumbar curves are the most suitable for this method of reduction. It is certainly contra-indicated when tuberculosis is present elsewhere, when there is much wasting, when the child suffers from some respiratory disorder, when abscesses are present, when ankylosis has taken place, when considerable alterations in the bony frame-work of the chest have occurred, when the patient is more than twenty years of age, and when the curves are in the cervical region. The results of respiratory embarrassment are so serious that I have modified Calot's method by substituting for the plaster corset a special splint modeled from a Thomas hip-splint, with a head-piece to maintain extension of head and neck; further, the plaster jacket is likely to give rise to pressure-sores, to say nothing of its discomfort in warm weather and the impossibility of keeping either child or corset clean. A. H. Trebby (Practitioner, Lond., Jan., '98).

RHEUMATISM, ACUTE ARTICULAR.

Great relief may sometimes be had by applying, with gentle friction, the following:—

℞ Salicylic acid, 4 drachms.
Sodium salicylate, 3 drachms.
Extract of belladonna, 1 drachm.
Vaselin, 25 drachms.

When applied, the parts should be well covered with cotton-wool and kept at an even temperature. Lemoine (Nord Méd., Feb. 9, '98).

RIGHT- AND LEFT- HANDEDNESS.

Physiology.—It is probable that the child is born equally expert in both hands and both legs, and that the subsequent superior dexterity of the right hand and foot is due to careful training on the part of the nurse or parent. Left-handedness is probably started by a burn, strain, or injury of the right hand during the critical period of babyhood. It is of great advantage to anyone, especially the surgeon, to cultivate ambidexterity, and Alexander Mott, Joseph Pancoast, Samuel F. B. Morse, Leonard da Vinci, and Michael Angelo were notable in this respect. The crossed fibres to either brain are probably a form of "switching-off" apparatus, intended only for temporary use, and all arguments based on anatomy as forcing right-handedness are probably weak. George M. Kellogg (Jour. Amer. Med. Assoc., Feb. 12, '98).

SENILE GANGRENE.

Treatment.—When the gangrene is limited to one or two toes and the patient's condition is satisfactory, be content with the expectant plan of treatment, taking precautions to lessen or prevent the effects of local septic infection. When, however, the gangrene has reached the metatarsus be prepared to perform amputation above the knee, or, in rare and favorable cases, through the knee-joint itself. The local treatment in limited forms of gangrene should consist in thorough cleansing of the foot and leg, free dusting of the immediate vicinity of the dead part with iodoform, and the application over this powder of sublimate or salicylic wool. The use of artificial heat in the form of poultices and fomentations must be discarded as not only ineffectual, but positively mischievous. Pain may be relieved by the internal administration of opium and local application of a powder composed of boric acid, subcarbonate of bismuth, and muriate of morphine. A case is reported of amputation through the lower third of the thigh for gangrene of the leg, in a man, aged 57, who a fortnight after the operation was pronounced to be out of danger and making a very good recovery. Jones (Med. Chron., Jan., '98).

SPERMATIC CORD, SPONTANEOUS TORSION OF.

This occurrence is something more than a mere curiosity, for, in a case recently reported to the Paris Anatomical Society, it was mistaken for strangulated hernia. An operation was undertaken, but, in place of a hernia, there was found a twist in the spermatic cord that had led to gangrene of the testicle, which had to be removed. The testicle was not displaced and the patient had not had gonorrhœa. The cause of the torsion was not ascertained. Barozzi (Gaz. Heb. de Méd. et de Chir., March, 3, '98).

SUPPURATIVE INFLAMMATION.

Sodium bicarbonate in 2-per-cent. solution, tried many times, invariably stopped the pain and the suppuration and effected a cure without drainage. Georzensky (Med. Rec., March 26, '98).

TACHYCARDIA.

Etiology. — In certain cases of so-called "nervous" palpitation the underlying cause is uræmic intoxication. In other cases the tachycardia is the first symptom of exophthalmic goitre, and precedes, by many years, the other symptoms. Of fifty-five cases of Graves's disease thirty-four came under this heading. Curtin (Internat. Med. Mag., Feb., '98).

Book Reviews.

Traitement des Fractures par le Massage et la Mobilisation, le Dr. J. Lucas-Championniere. Morocco, Square Octavo, pp. 564. Rueff et Cie, Paris.

The author is so well known, both at home and abroad, for the thorough manner in which he treats any subject that tempts his pen, that it seems almost like a work of supererogation to attempt a review of this most complete and interesting work. Dr. Championnière is, moreover, the pioneer in the treatment of fracture by massage and mobilization. He recently exhibited at the Academy of Medicine in Paris a patient[1] in whom a fracture of the lower end of the radius had been treated by this method. There had been a great deal of movement between the bones and it had been found impossible to immobilize the fragments. Massage and immediate movement were found sufficient to restore the power of useful motion and to bring about rapid consolidation of the fracture in a good position. Dr. Championnière took advantage of the occasion to remind his audience that he had employed this method for thirteen years and always with great success, and never during this time had he employed a plaster bandage or any other kind of immobilizing apparatus. In fifty cases of fracture of the clavicle he had obtained by massage far superior results to those given by the most perfect form of immobilizing apparatus. In the case of fracture of the humerus which he showed the fracture was one of the worst kind at a place just above the elbow-joint and comminuted. The man suffered great pain, and the least movements dislocated the elbow-joint. During the first four days the elbow was placed in a molded splint; from the fifth to the eighteenth day the arm was supported by an ordinary sling and after that had no support at all. The mere weight of the limb sufficed to keep the fragments in a good position. From the first day the patient was massaged the acute pains rapidly disappeared. As soon as the limb appeared to be so firmly united that no chance of future displacement was likely the patient left the hospital,—on the twenty-eighth day,—but continued to attend as an out-patient. In place of six weeks, which was the time ordinarily given as necessary for a fractured humerus to unite, the bone in the present case was quite firm in less than three weeks, and in addition to the treatment used was almost painless. During the last two years Dr. Championnière has treated more than twenty cases of similar fractures of the radius, of the scapula, and of the leg. Immobility did not favor repair of the tissues; movement was necessary for repair, for movement was a necessity of life. Finally, Dr. Championnière affirms that immobility as a therapeutic method should be made to disappear from surgery. M. Péan recently confirmed the excellence of the results obtained by Championnière's method. It was especially useful when there was not great displacement of the fragments. If the displacement was too considerable, the lack of any immobilizing apparatus

[1] Report in The Lancet, London.

brought about, in his opinion, union in a bad position, which necessitated an operation later. M Labbe considered that massage was excellent in articular and periarticular fractures, but that there were other kinds of fractures in the middle of a long bone and especially fractures of the lower third of the leg; to treat such in any other way would be to expose the patient to the risk of a false joint forming: a result which has become only too frequent of late years and which M. Labbe attributes to the too general use of the method of Championnière. The latter, in closing the discussion, maintained that immobility appeared to him to bring about a condition of lowered vitality in a limb, while what was an active process of repair. He would move the osseous fragments every time that there was no muscular spasm to pull them out of place, but he agreed with M. Labbe that in a certain number of fractures—notably those of the lower third of the leg—the old fixation treatment ought to be maintained. He has worked out statistics comparing accidents occurring in fractures treated by immobilization and by movement, and found that they were very much more common in the first class than in the second.

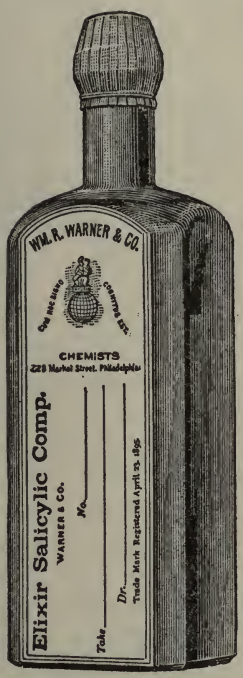
Monographs Received.

The editor desires to acknowledge, with thanks, the receipt of the following monographs:—

Annual Reports, Department of Agriculture. Washington, D. C., 1897.——Medical Report, Society of the Lying-In Hospital of the City of New York, 1897.——The Treatment of Carcinoma of the Stomach. J. M. G. Carter, M.D., Waukegan, Ills.——Roentgen-Ray Diagnosis of Pulmonary Tuberculosis and Other Diseases of the Lungs and Heart. By J. Edward Stubbert, M.D., Liberty, N. Y., 1898.——The Inunction of Mercury in Tertiary Syphilis of the Nose and Throat. By St. Clair Thomson, M.D., London, Eng., 1898.——The Operative Treatment of Hæmorrhoids. By Parker Syms, M.D., New York, 1898.——Note on Diastatic Preparations. By W. G. Tucker, M.D., Albany, N. Y., 1898.——Electric Treatment in Gout and the Uric-Acid Diathesis. By Robert Newman, M.D., New York, 1897.——Eczema: Successful Treatment. By J. Hobart Egbert, M.D., Holyoke, Mass.——The Present Status of Puerperal Infection. By R. R. Kime, M.D., Atlanta, Ga., 1897.——Some Practical Thoughts on the Development of the Human Race and Obstetric Nursing. By R. R. Kime, M.D., Atlanta, Ga.——On a Second Case of Removal of a "Pressure Pouch" of the Œsophagus. By H. T. Butlin, England, 1898.——The Virile, or Bulbo-Cavernous, Reflex. By Prof. C. H. Hughes, M.D., 1898.——Acute Inflammation of the Antrum of Highmore. A New Electrical Nasal Saw. By F. C. Cobb, M.D., Boston, Mass., 1897.——Notes on the Non-surgical Treatment of Boils, Carbuncles, and Felons. By L. D. Bulkley, A.M., M.D., New York, 1897.——Difficulties in Determining the Causes of Coma. By J. T. Eskridge, M.D., Denver Col., 1897.——The Antitoxin Treatment of Tuberculosis. By Charles Denison, A.M., M.D., Denver, Col., 1898.——A New Incision for Arthrectomy, Resection, and for Reduction of Irreducible Dislocation of the Shoulder-joint. By N. Senn, M.D., Chicago, Ill., 1898.——On Micrococcus Gonorrhœæ and Infection. By Alexander G. R. Foulerton, 1897.——Treatment of Chronic Empyema of the Antrum of Highmore by Temporary Osteoplastic Resection of the Anterior Antral Wall. By N. Senn, M.D., Chicago, Ill., 1897.——A New Method of Nerve-resection for Amputation-neuroma. By N. Senn, M.D., Chicago, Ill., 1897.——Lumbar Nephropexy without Suturing. By N. Senn, M.D., Chicago, Ill., 1897.——Epidemic Influenza, or La Grippe: Its Different Phases and Nervous Tendencies. By W. O'Daniel, A.M., M.D., Bullards, Ga.,

1897.——Case of Ruptured Tubal Pregnancy; Laparotomy; Recovery. By A. L. Smith, M.D., Montreal, Can.——Experience of Two Hundred and Forty-nine Abdominal Sections. By A. L. Smith, M.D., Montreal, Can., 1898.——Railroad-surgery: Operation and Recovery. By W. O'Daniel, M.D., Bullards, Ga., 1897. ——After Gynæcological Operations. By C. A. von Ramdohr, M.D., New York, 1897.——Second Annual Report of the Board of Managers of the Pennsylvania Epileptic Hospital and Colony Farm, 1897.——Our Foreign Trade in Agricultural Products During the Five Fiscal Years of 1893-1897. Prepared by F. H. Hitchcock. U. S. Department of Agriculture, 1898.——Experimental Station Work. III. U. S. Department of Agriculture, 1898.——The Principal Insect Enemies of the Grape. By C. L. Marlatt, M.D. U. S. Department of Agriculture, 1898.—— Repairs of Macadam Roads. By E. G. Harrison, C.E. U. S. Department of Agriculture, 1898.——Des Adénoidites Chez les Adultes. Par le Dr. E. J. Moure, Bordeaux, France, 1898.——Traitement Electrique Palliatif de la Névralgie du Trijumeau. Par le Dr. J. Bergonié, Bordeaux, France.——Remarks on Laminectomy, with Report of a Case Done Sixteen Months After Fracture. By Oscar J. Mayer, M.D., San Francisco, 1897.——Some Statistical Observations on the Etiology and Symptomatology of Dementia Paralytica. By A. W. Hoisholt, M.D., Stockton, Cal., 1897.——Multiple Neuritis Following Influenza. By Herman B. Allyn, M.D., Philadelphia, 1897.——The Scholar in Medicine. By J. M. Da Costa, M.D., LL.D., Philadelphia, 1897.——Headaches from Nasal Causes. By Sargent F. Snow, M.D., Syracuse, N. Y., 1897.——Serum-therapy in Tuberculosis. By Hoell Tyler, M.D., Mentone, Cal., 1897.——Sero-therapy in Tuberculosis; Report of Cases Treated with Serum. By Hoell Tyler, M.D., Mentone, Cal., 1896.—— Multiple Sarcomata in an Infant. By Augustus A. Eshner, M.D., Philadelphia, 1897.——Two Cases of Epilepsy. By Augustus A. Eshner, M.D., Philadelphia, 1897.——Hysteria in Early Life. By Augustus A. Eshner, M.D., Philadelphia, ——Traumatic Hysteria. By Augustus A. Eshner, M.D., Philadelphia, 1897.—— Hereditary Lateral Sclerosis. By Augustus A. Eshner, M.D., Philadelphia, 1897. ——Chronic Follicular Tonsillitis. By W. Scott Renner, M.D., Buffalo, N. Y., 1897.——The Bacteriology of Tuberculosis. By Charles F. Craig, M.D., Danbury, Conn., 1897.——On Variations in the Morphology of the Bacillus Tuberculosis. By Charles F. Craig, M.D., Danbury, Conn., 1897.——Notes on the Pathology and Bacteriology of Appendicitis. By Charles F. Craig, M.D., Danbury, Conn., 1897. ——Bloodless Vaginal Myomectomy. By Oscar J. Mayer, M.D., San Francisco, Cal., 1894.——Massage in Gynæcology. By Oscar J. Mayer, M.D., San Francisco, Cal., 1894.——Early and Radical Operations in Cancer of the Breast, and A New Symptom for Early Diagnosis. By Oscar J. Mayer, M.D., San Francisco, Cal., 1895.——Treatment of Cancer of the Rectum, with a Report of Twenty-five Cases. By W. W. Keen, M.D., LL.D., Philadelphia, 1897.——Clinical Lecture on An Obscure Tumor of the Abdomen—Amputation of the Breast for Paget's Disease Followed by Cancer—Tuberculosis of the Tonsil and Soft Palate, by a Method Which Avoided Splitting of the Cheek or Dividing the Jaw. By W. W. Keen, M.D., Philadelphia, 1897.——Addresses at the Unveiling of the Bronze Statue of the Late Prof. Samuel D. Gross, M.D., Erected by the American Surgical Association and the Alumni Association of the Jefferson Medical College, Washington, D. C., May 5, 1897.——The Technique of Professor Keen's Surgical Clinic in the Jefferson Medical College Hospital. By Thomas Leidy Rhoads, M.D., Philadelphia, 1897.——Address in Surgery. By W. W. Keen, M.D., LL.D., Philadelphia, 1897. ——Literary Methods in Medicine. By W. W. Keen, M.D., LL.D., Philadelphia. ——Resection of the Sternum for Tumors, with a Report of Two Cases and a Table of Seventeen Previously Reported Cases. By W. W. Keen, M.D., LL.D., Philadelphia, 1897.

[End of the Editorial Department of the Monthly Cyclopædia for April, 1898.]



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To the Medical Profession. — M. J. Breitenbach Co., New York, have issued a circular denying a report that Gude's Pepto-Mangan is advertised on walls, fences, etc. They quote a clause in their contract forbidding them to attempt to increase their business in that preparation other than through the recognized channels to the medical profession under penalty of forfeiture of the contract.

Notes and Comments (continued).

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Notes and Comments (*continued*).

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A Fugitive King's Fete.—"About four miles from Philadelphia there was a magnificent mansion built after the Italian manner in the previous century by Governor John Penn, and known as Lansdowne House in honor of the Marquis of Lansdowne. Here Joseph Bonaparte," records William Perrine, writing in the April Ladies' Home Journal, of "When the King of Spain Lived on the Banks of the Schuylkill," "established himself in rural ease until he had built his 'palace' at Bordentown, New Jersey. Toward the end of the summer of 1817 Joseph had a little dinner-party at Lansdowne. Among the guests was Dr. Benjamin Rush's daughter, Julia, who was pleased with what she thought his fluent conversation, his urbane manner, and his good looks, and who, perhaps, was somewhat inclined to sympathize with his complaint that Napoleon had not been at all disposed to let him have very much of his own way as either soldier or King.

"On one occasion only he gave a magnificent fête on the lawn of his princely estate, and the beaus and belles of Philadelphia who had been invited dressed

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Notes and Comments (continued).

in their most picturesque summer gowns and made haste to attend. It was a brilliant afternoon fête, and Bonaparte was the centre of attraction as he stood on his lawn and welcomed his guests. But it is doubtful whether there were at any time more than half a dozen persons in Philadelphia, or for that matter in the whole country, to whom he bore anything like close and confidential relations. He liked little children, and they were sometimes in the habit of speaking of him as 'the good Mr. Bonaparte.'"

Thiol in the Treatment of Atrophic Rhinitis.—Dr. H. L. Armstrong writes, in the New York Medical Journal, that faithful and careful cleansing of the parts is of much importance in atrophic rhinitis. The best method of doing this is the daily use of the syringe with pure hot water. The syringe manufactured by Tiemann & Co., with a short nasal tip for use in the anterior nares, with a shifting shield which has a post-nasal tip also, is one that can be relied upon for thorough cleansing of the nasal lumen and post-nasal space. As a means of giving rest to these overwrought, worn, and exhausted parts, after such cleansing, it is desirable to find some remedy that will physiologically put the parts in splints. This I believe I have found in the following prescription:—

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Pain in Otitis.—Dr. George H. Powers, Professor of Ophthalmology and Otology in the University of California, San Francisco, in an article in The Medical News, writes as follows, in reference

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Disinfection and Deodorization.—From "Some Points in the Treatment of Typhoid Fever," an article in March 12, 1898, issue of New York Medical Journal by Dr. John A. Larrabee, Professor of Diseases of Children and President of the Hospital College of Medicine, Louisville, Ky., we quote:—

"The multiplicity of unreliable disinfectants, and the common idea regarding any deodorant as a disinfectant, works much mischief, Dr. Larrabee is convinced. While disinfectants are multiplied beyond enumeration, the principle upon which their germicidal qualities depend remains the same. The agent, to be effective, he says, must liberate nascent oxygen in the presence of the germ. Nothing has yet been discovered as a dusting-powder which can equal chlorinated lime. Labarraque's solution of the hypochlorites and Platt's Chlorides are the best liquid preparations. Oxygenation by these, or actual combustion by fire, is alone to be thought of."

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Various Uses of Vegetable Oils.—Under this title Dr. J Alexander Wade reports in the New England Medical Monthly four cases in which marked improvement followed the use of Trinolea, an emulsion prepared by the Keller Pharmacal Company, of Baltimore, M.D. The cases were of enlarged scrofulous glands of the neck, slow convalescence after grippe, chronic eczema due to malnutrition, and debility following prolonged nervous strain. Trinolea is a stable emulsion of olive-oil, peanut-oil, and oil of maize-germ. Dr. Wade says: "I have purposely produced these four cases suffering from different diseases, in order to show the especial value of this combination and the range of its therapeutic power. A close examination of its substance shows it to be a rich, creamy emulsion, delicious in taste, and hence acceptable to the most fastidious stomach." The mixture was given in tablespoonful doses.

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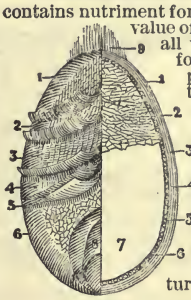

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Specimen page from Grandin and Jarman's "Obstetric Surgery."

As the cord comes down it is to be drawn upon from the *placental* side, and if it is over one of the legs it must be released (Fig. 53) and placed in the most favorable position as regards pressure. In rare instances it will be impossible to draw the cord down without making undue traction. If such should prove to be the case, it should be secured by means of two artery-clamps and cut. Of course, if this is done, it will be necessary to hasten the delivery as much as possible.

When the scapulæ appear the arms must be liberated before extraction is continued. Under favorable circumstances, —that is, if the assistant has kept up intelligent pressure on the fundus, or if the cervix was fully dilated previous to the

Fig. 53.—Method of Releasing the Cord.

version, or if the operator has not made traction in too rapid a manner,—the arms will be folded on the chest and their extraction will be easy.

Even in the hands of the best operators and with the best assistants the arms sometimes become unavoidably extended. Although their extraction must be accomplished in as rapid a manner as possible, there is no need of breaking the arm if care is taken.

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